DISSERTATION

EXPLORING THE MEANING OF CANCER IN THE LIVES OF HIGHER EDUCATION TEACHERS

Submitted by

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WE HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER OUR SUPERVISION BY HENRY H. JORDAN III ENTITLED: "EXPLORING THE MEANING OF CANCER IN THE LIVES OF HIGHER EDUCATION TEACHERS" BE ACCEPTED AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY.

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ABSTRACT OF DISSERTATION

EXPLORING THE MEANING OF CANCER IN THE LIVES OF HIGHER EDUCATION TEACHERS

The purpose of this study was to examine the meaning of cancer from the viewpoint of higher education teachers who had experienced cancer. Types of cancer included prostate, thyroid, breast, colon, and ovarian. The participants ranged in age from 48 to 65 years. Years teaching since diagnosis ranged from 2 to 20 with a total of 43 years. The current health status of the participants ranged from good to excellent.

A qualitative approach was used to gather information from 9 higher education teachers. All 9 participants were currently teaching at local colleges and universities in Atlanta. A series of semi-structured, face-to-face in-depth interviews were conducted with each participant and the data were recorded and transcribed verbatim. The interviews followed a five-question interview guide. The first question asked about the diagnosis and prognosis, while the remaining four questions focused on cancer and its effect on one's professional life. The researcher, also a cancer survivor, invited the participants to openly share their cancer journeys.

The resulting data were analyzed using the constant comparative method of data analysis and interpretation. From the analysis three major themes emerged: (1) the nature of cancer, (2) dealing with cancer, and (3) the outcomes of cancer. Each major theme has three sub themes. Connecting the major themes was the concept of *time*, both chronological and phenomenological.

The participants worked to understand their disease as well as how the disease affected them. Several participants viewed cancer as a major life-changing experience, while others minimized the life changing effects.

From the participants' words, a description of their survival experiences resulted. The study concludes with practical advice from the participants for others who face cancer or are interested in learning about these life experiences.

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Life is a loving teacher.

There are so many people who have helped me with my cancer that I cannot remember them all, and to name a few would be a disservice to all the others. Is the recognition of a surgeon any more important than the recoginition of a night nurse or orderly? I think not. They have all helped me in their special way. Thus I would like to acknowledge all of the people at St. Joseph's Hospital in Atlanta for all that they have done for me.

I am indebted to my major professor, Dr. Ann Foster, for helping me realize my potential. She has become more than an academic advisor, always willing to help and share. All students should be so fortunate as to have a unique individual like Dr. Foster on their dissertation journey.

In addition, I am indebted to my other committee members who provided guidance and advice: Drs. Len Albright, Jim Banning, and Kevin Oltjenbruns. I thank you for your wisdom, support, and confidence.

This research was only possible through the help and support of the participants who gave of themselves. It is my hope that because of their willingness to share, this research can help others.

I am grateful to my family at St. Timothy Methodist Church for their encouragement, prayers, and warm hugs.

To my brothers Mike and Pat, sister Sandi, and my extended family, I thank you for your love and caring.

"You cannot edit what you do not write!" Bebe, my wife, often reminded me. She was right. Without her, this research would not have made it to completion. She pushed me when I did not feel like writing. She has always maintained the steadfast belief and conviction that I could do it. What a blessing she has been to my life.

Finally, even though I acknowledge God last, God is first in my life.

DEDICATION

This research is dedicated to the loving memory of my parents, Hildegarde Catherine and Henry Hellmut. My father taught me how to be a business man, while my mother taught me how to be a gentle man. While they are no longer physically with me, they are always within me. As they watch me from Heaven I hope that I make them proud. I am who I am today because of them.

IT WAS ONLY MY HAIR

(A poem by the author, composed from the
words of Micky, my pilot study participant)

It was only my hair!

I had just reached the point
After all these years of battling
"Straight"
vs
"Permed"
That my hair and I were now friends;

But poison was pumping through my body
Trying to rid me of all that was evil
So that I could go on living—
And all the while my hair was dying

As I looked into the mirror
I saw myself with no hair,
And I cried for the very first time
Then it hit me like never before;

I really had cancer
It wasn't happening to someone else.
It was really happening
And it was really happening to me.

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CHAPTER 1

INTRODUCTION

Cancer touches not only the lives of its victims but also the victims' families, friends, and colleagues. In contrast to past public attitudes of secrecy about cancer, cancer is now discussed openly in public, visualized on billboards and television, and talked about in the workplace and in private settings. The incidence of cancer has grown so much that many adults know at least one person who has cancer or knows someone who knows someone who has cancer. The reality is also that as people are living longer, the number of people with cancer will also increase.

As technology improves and life span increases, more adults are able to return to work after being diagnosed and treated for cancer. Although the incidence of cancer is increasing, so is the survival rate. Several studies have used survey instruments to measure concepts such as quality of life, coping styles, hope, and reactions to a diagnosis of cancer (Arraras, Wright, Jusue, Tejedor, & Calvo, 2002; Chapman, 2000; Cohen, 2002; Kayser, Sormanti, & Strainchamps, 1999; Wall, 2000). However, none of these studies has taken into consideration that living with cancer and its many emotional and psychological dimensions remains a highly complex, time consuming journey that may be better understood through qualitative research.

Purpose of the Study

The purpose of this study was to look at the lives of college teachers, myself included, who have had cancer and to better understand how their individual experiences have affected and continue to affect their teaching. In addition, this study will help educational professionals better understand how teachers who have survived cancer consciously or unconsciously alter their philosophy of teaching and its implementation as a result of that experience.

Finally, this study will be a small step in contributing to a broader understanding of the complex issues of returning to teaching after encountering a life-threatening illness such as cancer. The knowledge to be gleaned from the individual experiences and personal perceptions will be beneficial to teachers, administrators, families, and institutions in order to better assist and understand the personal journey of a cancer survivor.

Qualitative Research

As both researcher and participant, I know first hand what it is like to have your body, mind, social life, and spirituality changed and challenged. To get to the essence of the cancer experience, a qualitative approach using grounded theory opens the door to explore this phenomenon.

A qualitative approach paves the way to conduct a detailed and thorough investigation of the factors that affect one's professional life after experiencing cancer. The term *qualitative research* is defined by Strauss and Corbin (1998) as "any type of research that produces findings not arrived at by statistical procedures or other means of quantification" (pp. 10-11). According to Merriam (1998), when there is little information about a topic, the qualitative approach is ideally suited. The research should be conducted in a natural setting to collect rich and thick data (Bogdan & Biklen, 1998; Merriam, 1998). It is these rich descriptions (data) of the world that are valuable (Denzin

& Lincoln, 2000). Thus, immersion in the participant's world by the researcher is desirable.

Guiding Frameworks

This study is about people but more specifically about higher education teachers who have had their lives affected by cancer. It is about their strategies and mechanisms for continuing their professional life after and in spite of their disease.

My qualitative research will be based on grounded theory methodology, more commonly referred to as *grounded theory*, which was originally developed by Barney Glaser and Anselm Strauss (Strauss & Corbin, 1998, p. 9). The main focus of grounded theory is on inductively generating ideas from the data as opposed to testing theories ahead of time (Gibbs, 2002, p. 165) or, as Moustakas (1994) wrote, "The focus initially is on unraveling the elements of the experience" (p. 4). A grounded theorist "constructs a picture that draws from, reassembles, and renders subjects' lives. The product is more like a painting than a photograph" (Charmaz, 2000, p. 522). According to Denzin and Lincoln (2000), "Constructivist grounded theory becomes a very powerful framework for implementing multiple approaches to social life" (p. 374).

As a qualitative researcher, with my participants' help I will learn about their social experiences and how they give them meaning. By using qualitative inquiry as the looking glass, we will understand human behavior and experience from the perspectives of those being studied (Bogdan & Biklen, 1998). In addition, since interpretivists (constructivists) assume multiple, socially constructed realities or qualities that are complex and not defined by discrete variables, understanding and interpretation of a participant's world is best explored and explained using a qualitative paradigm (Glesne, 1999).

Initial Theory

During the summer and fall of 2002, I completed two courses at The University of Georgia in qualitative research. In the first course, Designing Qualitative Research, I designed, developed, and completed a pilot project to explore the theory that higher education teachers who have survived cancer consciously or unconsciously alter their philosophy of teaching and its implementation as a result of that experience.

Moustakas (1994) stated that theory is generated from the research and data collected and that hypotheses and concepts derive from the study and analysis of the data (p. 4). Prior to the start of the project, I had to receive clearance from the Human Subjects Office. The pilot study is contained in Appendix A. In the second course, Qualitative Data Analysis, I used my interview data from the pilot study and analyzed it using a variety of methods. These methods included inductive analysis, thematic analysis, narrative analysis, conversational analysis, phenomenological analysis, and poetic interpretation. The poem about Micky in the opening pages of this document is an example of poetic interpretation. It is the analysis of the data that becomes important; as Silverman (2000) wrote, "The validity of qualitative analysis depends more on the quality of the analysis than the size of the sample" (p. 42).

This initial theory, grounded in the data, provided a preliminary framework for understanding the meaning of cancer in one's life and also provided a basis for how the various concepts and themes might be organized and connected.

The conceptualization of Figure 1 emerged from my pilot study with Micky (a pseudonym), a higher education female teacher who had been diagnosed and treated for breast cancer in 2001. This figure is a visual representation of my conceptual framework showing the primary areas researched (Miles & Huberman, 1994, p. 18).

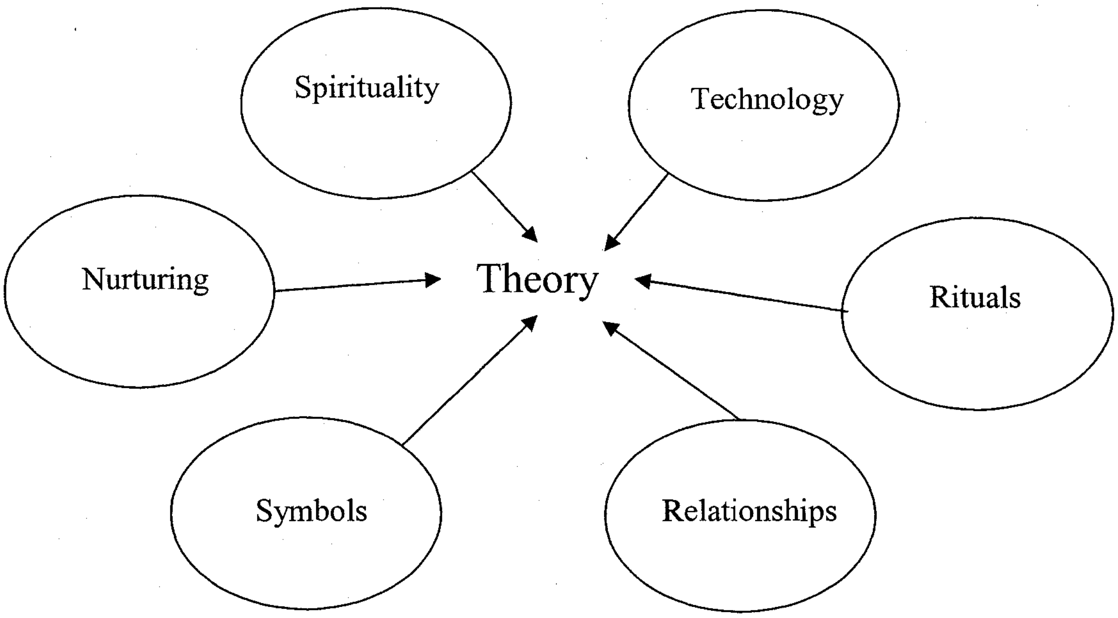

Figure 1. Visual representation of conceptual framework.

This pilot study was invaluable since it allowed me to gain hands-on experience as a qualitative researcher. As Glesne (1999) wrote, “A pilot study is useful for testing many aspects of your proposed research” (p. 38). Specifically, I learned about interviewing, observation techniques, journaling, memoing, and myself.

During my initial research these themes emerged, but other themes emerged as the research expanded. As a qualitative researcher using grounded theory, I collected and analyzed the data and travelled in the direction it led. This initial framework was my starting point and became my initial road map into the field for answering the following research questions.

Research Questions

These research questions focus on discovering the essence and meaning of a serious illness on the lives of higher education teachers. The following three overarching questions guided my exploration:

1. What is the essence of the experience of cancer for a higher education teacher?
2. How has cancer affected higher education teachers' professional lives?
3. How do higher education teachers who have experienced cancer describe teaching and learning after they return to the workplace?

CHAPTER 2

LITERATURE REVIEW

Cancer

After heart disease, cancer is the most common cause of death in the western world. As technology improves and life span increases, more adults are able to return to work after being diagnosed and treated for cancer. The incidence of cancer is increasing, but so is the survival rate. Murphy, Morris, Lange, and the American Cancer Society (1997) stated, "1.4 million Americans will learn they have cancer" and "of all those whose cancers are diagnosed today, more will survive than will die as a result of the disease" (p. 3). The American Cancer Society estimated that more than 563,000 Americans were expected to die from cancer in 2004, which is more than 1,500 people per day. In addition, the Society predicted that there would be more than 1,368,030 new cancer cases. Since 1990, there have been more than 18 million new cancer diagnoses (*Cancer Facts & Figures 2004*, 2004, pp. 1-2). The lifetime risk of developing cancer for someone living in the West is 30 percent, and there is a 20 percent risk of dying from cancer (Bowling, 2001).

Since diagnosis of cancer is usually in later years and people are living longer, the likelihood of developing cancer is increased. If a person was born in 1841, his or her life expectancy was about 41 years, but a person born today can expect to live until age 78 (Larson & Mayo Clinic, 1996, p. 232). These differences in life expectancy seem to be due to changes in biology, genetics, and environment (Larson & Mayo Clinic, 1996). At the beginning of the 20th century, people in the United States had an average life span of about 50 years. By the end of the century, the average life span had risen to 76 years. Other developed countries experienced similar increases. In 2000, the US census (*65 Years and Over Population: 2000*, 2001) counted more than 35 million people over the age of 65. According to the Census Bureau, this represents a 12 percent increase since 1990. The 1990 census revealed that the number of Americans over 65 years old has more than doubled since 1950 and jumped from 25.5 million to 31.1 million from 1980 to 1990 ("Microsoft Encarta Reference Suite 2001", 2001). The 2000 US census (*Population Change and Distribution: 1990 to 2000*, 2001) counted 281.4 million people, which represents a 13.2 percent increase from the 1990 census population of 248.7 million. This population growth of 32.7 million people represents the largest census-to-census increase in American history. In addition, the Bureau reports that according the 2000 census, 80.3 percent of the population lived in metropolitan areas. This number represents a slight increase from the 1990 census. These statistics become important as research shows that the risk for cancer increases as the environment becomes more toxic.

To simplify these statistics, "the lifetime probability of developing cancer is one in two in a man and one in three in a woman" (Lauria, 2001, p. 4); thus, more and more adults will be confronted with cancer in their lives. Since cancer often changes a person both physically and mentally, there are continuous needs for financial, emotional, spiritual, and medical support.

Many studies have used quantitative instruments to measure quality of life, coping styles, hope, and reactions to a diagnosis of cancer (Burgess, Morris, & Pettingale, 1988; Carlson, Bultz, Speca, & St. Pierre, 2000; Ell, Nishimoto, Mantell, & Hamovitch, 1992;

Miller & Powers, 1988; Padilla, Ferrell, Grant, & Rhiner, 1990; Reele, 1994). However, these types of studies do not take into consideration that cancer with its many emotional and psychological dimensions remains a highly complex subject. In fact, no one study can incorporate all relevant dimensions because the number of questions or measures would be too complex or would suffer from a high rate of non-response from patients (Bowling, 2001). It is hoped that other research methods will be used (such as case study) that are more suitable for understanding these complex and often abstract subjects (Reele, 1994).

Since 1994, several studies have explored the experience of returning to work after an illness or disability (Chapman, 2000; Mackay, 1998; Shaw, 1998). However, there have been no studies that provide an understanding of the journey of a higher education teacher with cancer. Suinn and VandenBos (1999) stated that in 1999,

> Three [percent] of the U.S. population (some 8 million) will need some form of cancer care. Of this segment, 1.2 million will be newly diagnosed with cancer and will begin treatment. Some, diagnosed in previous years, will continue treatment; others, who have been successfully treated and no longer show evidence of cancer, will still require follow-up; and over 500,000 will die from the disease. In addition, many others in the general population will require some form of cancer screening. (p. ix)

Given the magnitude of these numbers, it seems that you may be diagnosed with cancer or you will know someone personally, or that person will know someone personally who will experience cancer. While it is a common belief that the survival rate for cancer patients is increasing, no one can state with certainty what the future will be for an individual cancer patient; thus, this person has to live with uncertainty, and it is this uncertainty that affects how one thinks and interacts with others. Living with cancer affects one's physical being, financial resources, emotional needs, and spiritual needs.

These needs, in turn, become real costs of both time and money that for many become unbearable.

From the pilot study, the concepts of nurturing, relationships, spirituality, technology, rituals, and symbols emerged as shown in Figure 1. As the research progressed, other areas for review emerged. These initial topics provide both a grounding and springboard for this research. The following two theories, attribution and resiliency theories, were helpful in understanding possible causes for one's cancer as well as how one may overcome the disease.

Attribution Theory

One of the ways individuals try to gain control over a threatening event is to make causal attributions of the event. Attribution theory suggests that when one experiences a sudden threat or change in the environment, he or she will initiate a search for causes to understand the reasons for that threat or change to have occurred (Macleod, 2000, p. 321). The study of perceived causation is termed *attribution theory* (Kelley & Michela, 1980). How one perceives or interprets the cause or causes of an event will influence subsequent reactions and behaviors. These causal attributions play an important role in how one understands the world and his/her interactions with that world. The concept of causality—that is, how does one action or event cause another action or event?—has been a topic of interest in psychology and philosophy (Hubbard & Ruppel, 2002). The most basic form of causality is mechanical, such as when an object has contact with another object, causing the second object to move. Examples include a golf club hitting a golf ball or a hammer hitting a nail. These events are observable and easily understood. However, with non-visual events, such as the diagnosis of a disease, causality becomes more difficult. The passing of time, lack of memory, expectations, and other possible causes can influence one's belief about the real causes of the event.

In addition, Kelley and Michela (1980) stressed that there is "an interplay between prior beliefs and new information . . . which affect the information and are affected by it" (p. 472). Thus, when old factors and new factors combine, new behaviors may exhibit. Finally, factors such as self-esteem, confidence, self-preservation, and social status can influence one's objectivity for causality. Attribution theory becomes important when one realizes that past events and behaviors may influence one's expectations of the future.

Resiliency Theory

In the physical world, *resiliency* is the ability of a material to return quickly to its original form after squeezing, pulling, twisting, or bending. Examples of resilient materials include a tennis ball, a rubber band, a piece of wire, and a wristwatch. Wristwatches have two basic resiliencies to water. Some watches are water resistant, meaning they can have limited contact with water such as being under water for a limited length of time before they are ruined. Other watches are waterproof, meaning they can be underwater to extreme depths and for an extended length of time. These waterproof watches, like many humans, can withstand adverse conditions. We often think of these watches and humans as being rugged, hardwearing, and strong.

However, not all materials are resilient as each has an individual breaking or snapping point. Psychological resilience is a similar concept whereby a person may return to a normal state after experiencing a traumatic event or hardship. However, depending on one's resilience, one person may experience weakness, while another person finds strength.

Wolin and Wolin (1993) defined *resiliency* as the ability of individuals to have positive life outcomes despite negative life situations. The authors described seven resiliencies: (a) insight, (b) independence, (c) relationships, (d) initiative, (e) creativity, (f) humor, and (g) mortality (pp. 5-6). They discussed the self-righting tendencies and attributes of individuals who have learned how to love, work, and play well. By utilizing these resiliencies and uniting opposites of injury and repair, defeat and triumph, and fear and courage, one can attain *Survivor's Pride* (p. 8). Becoming and being a survivor involves living through an accident, illness, or bad experience.

In a classic study on resilience, Werner (1995) found that it is the human being, the family, and environmental resources that form a shield against the harmful effects of life stressors. Coutu (2002) mentioned the use of an imaginary plastic shield by healthy survivors of the Holocaust concentration camps. This protective shield was comprised of several materials including the use of humor, the ability to form attachments with others, and an inner psychological safe space. According to Coutu, resilient people possess three characteristics: (a) an acceptance of reality, (b) a deep belief, and (c) an ability to improvise (p. 48).

Ashcraft (2002) wrote about her 41-day survival journey at sea after encountering a hurricane and capsizing. During the hurricane, her fiancé was lost overboard, the masts were gone, and the engine became inoperable. In spite of these tragic events, she was able to overcome her fears. By being resilient, that is, accepting her situation, utilizing her experience and skill to jury rig a sail, and being able to listen to her inner voice when it said, “Don’t lose ground. Stay on course. Fight for your life” (p. 93), she was able to navigate to safety. It seems apparent that when people face hard realities, they act in ways that allow them to become superhuman.

Resilient people possess the ability to build bridges to cross over from a negative situation to a better future. Viktor E. Frankl (1984), an Auschwitz survivor and the developer of *logotherapy* (meaning therapy), realized that for him to survive the horrors of the camp, he had to discover a purpose for his living. He constructed a mental footbridge so he could leave the camp. He saw himself lecturing about his experiences so others could understand his experiences. By seeing himself on the outside, he rose above his immediate suffering, thus making his suffering tolerable. According to Frankl, logotherapy consists of three main avenues by which one arrives at the meaning of life. The first is by creating a work or a good deed. The second is by experiencing something or someone, such as love. The third and most important is that “even the helpless victim, of a hopeless situation, facing a fate he cannot change, may rise above himself, may grow beyond himself, and by so doing change himself. He may turn a personal tragedy into a triumph” (Frankl, p. 170).

Moore and Stratton (2003) described the experiences of 51 widowers as they adjusted to a new way of life. Moore and Stratton expressed the resiliency of these men “as the ability to return to a life that has meaning and satisfaction after the loss of a spouse” (p. 1). Using a grounded theory approach, Moore and Stratton let the voices of the widowers tell us about their journeys into widowhood. What emerged was the continuum of experiences through which these older widowers transited from being husbands to caregivers to widowers, and for some, to husbands again and even widowers again.

Although the authors portrayed 51 individual journeys, they described the widowed man as a person who sees himself as more capable and competent for having survived the stress of his loss. In addition, a widower may consider the loss philosophically and thereby find a deeper meaning to life. Finally, a widower may develop a desire to help others by sharing his own experiences. For many, the ability to share a story not only honors the person remembered but also becomes a way to share intense feelings while confirming one's reality. Moore and Stratton concluded by sharing information about widowers of the future and ways to adjust to widowhood.

In summary, to be resilient means to have the capacity to successfully adapt and adjust to adverse and traumatic life situations. A resilient person has to have a sense of worth, a sense of power, a sense of hope, and a sense of competence.

Nurturing

To *nurture* means to help one grow, develop, or thrive. There are numerous ways to practice nurturing, and each person finds his or her own way to give and receive nourishment. One can give and receive nourishment by extending care, concern, and help. Mentoring is a common form of nurturing exhibited by humans and animals. Examples include when a teacher takes a struggling student under her wing or when a grizzly bear helps a stranded cub in the wilderness. Nurturing allows a society to grow; without a nurturing spirit, society can crumble. However, to allow nurturing to occur people must be receptive to change as well as have the capability to take control of their situation. In *Love, Medicine & Miracles,* Siegel (1986) discussed the will to live and how individuals must take control in order to heal themselves with the help of others. "It's important to realize that we can't force others to change, we can only help them to change themselves" (Siegel, p. 109).

Other changes include possible loss of employment, increased dependence on others, a change in priorities, an increased appreciation for life, and an increase in spirituality and religion. Siegel (1986) asked, "Why did you need the illness?" (p. 108). According to Siegel, this question helps the patient understand the psychological needs that the disease may meet, such as making it easier to say no to unwelcome burdens, duties, jobs, or the demands of other people.

For some, the reality of cancer is brought home by the intensity of the journey, and, as a result, they may turn to their spirituality and religion for support. Lauria (2001) wrote, "Prayer, rituals, sense of community, and a belief in the grand plan of a higher power can be very comforting to many" (p. 35). Even with a strong foundation, many find their faith challenged. Those who have strayed from their religion may experience guilt and self-blame for their illness.

Relationships and Support Groups

Relationships are the foundation of life. People have many types of relationships, such as with humans, animals, nature, and a supreme being. Survivors of cancer find comfort and support from meaningful relationships. Individuals change over time due to their experiences. Cancer can certainly alter relationships both inside and outside the family. Some relationships grow stronger and tighter over time, while other relationships seem to die a slow death. However, according to Holland (2000), the divorce rates are no higher among cancer patients than among the healthy population (p. 212).

Relationships with friends also change, as they may not know how or what to say or even how to handle a change in the appearance of the ill person. Sometimes knowing someone with cancer may bring about thoughts of one's own death, or it may bring back painful thoughts of a lost loved one (*Life after cancer*, 2001).

For the sick person, there is an increased dependence upon others and a sense of loss of control, which may eventually affect the balance in the home. When the cancer survivor experiences the loss of a significant other, either through divorce, conflict, or death, the burden of coping is increased (Holland & Lewis, 2000, p. 212).

Support groups can be a good source for help and understanding. For many patients and their families, participation in support groups is a means for seeking assistance for a wide variety of issues (Magen & Glajchen, 1999). These groups provide a way to meet others with cancer and also a way for family members to share concerns and coping strategies. Since cancer can make someone feel alone and isolated from the rest of the world, it is helpful to know others who have similar thoughts, feelings, and experiences (Hermann, Wojkowiak, Houts, & Kahn, 1988; Murphy et al., 1997).

According to Goodare (1994), even though support groups seem to be beneficial, there are some cancer patients who do not attend these groups or do not find them to be the right environment for facing some issues. Support and self-help groups meet face-to-face, over the telephone, and via the computer. Frequently support groups have been regarded as synonymous with self-help groups. However, there are two distinct differences: (a) support groups have a professional leader, and (b) support groups have a system of reciprocal helping (Magen & Glajchen, 1999).

Based on the literature, there are three modes of operation for support groups: (1) traditional face-to-face, (2) telephone support, and (3) computer based. All three modes have positive and negative aspects.

Face-to-Face Support

Coreil and Behal (1999) conducted a study designed to identify ways to strengthen the support group for men with prostate cancer as it expanded nationally and internationally. Specific objectives were to identify the characteristics and operations of man-to-man groups currently active in Florida; to determine the background, social profile, and perceived needs of man-to-man group facilitators; and to describe the social profile, medical status, and perceived needs of man-to-man group participants. The research showed that a large percentage of both physicians and patients rated support groups as good sources of emotional support for coping with the disease.

One theme that emerged in the Coreil and Behal (1999) study was that one cannot always rely on physicians and their staff to provide the most comprehensive and up-to-date information about treatment issues, so it is up to the patient and his family to stay as informed as possible. Most of the participants felt that they got needed information too late. The current findings point to the need for greater involvement of practitioners in early referral of prostate cancer patients to support groups. Additionally, local groups might build stronger ties with practitioners by placing newsletters or pamphlets in hospitals and urologists' offices.

In another study of face-to-face support groups, Heller (1997) wanted to examine the predictors of support group participation among families of persons with mental illness. The study recruited 12 family support groups from the Chicago metropolitan area and two from the southern Illinois area. Professionals led four of the groups, and family members of persons with mental illness led the rest. The group sizes ranged from four to 26, with a mean of 13. The study showed that support groups promote a psychological sense of community in which members provide acceptance, understanding, practical advice, and guidance. Further, the study revealed that the opportunity for an individual to identify with others who share a similar experience might help them to reduce feelings of isolation and shame.

Helping others may also engender a sense of purpose and meaning and otherwise devastating life circumstances. Another benefit of the support group is the education of family members about the causes, symptoms, and most recent advances in the treatment of mental illness. The most popular reason participants reported for attending a group was to receive emotional support. Heller's (1997) study is unique in its exploration of the reasons why some support group members decide to continue their involvement while others discontinue. Despite the phenomenal growth of family support groups, little is known about who typically joins, the motivational factors for voluntary participation, and what leads some families to discontinue their involvement.

When comparing the behavior of men diagnosed with prostate cancer and women diagnosed with breast cancer and their responses to participation in support groups, Krizek (1999) found that there were no significant differences between men and women as to how important it was to share concerns with other cancer patients and to compare their progress. Preliminary analysis showed that the most common reason for not attending was that the respondent did not feel any need for support. An unstated hypothesis might have been that women would come for emotional support and togetherness and men would come for information. This is based on the premise that men were unlikely to look to other male cancer patients for emotional support. Surprisingly, men reported no less interest than women did in sharing this support.

Telephone Support

Can support via the telephone be as effective as traditional face-to-face support? To explore this question, Brown (1999) developed a study utilizing a quasi-experimental design with two groups of participants: urban onsite groups and rural telephone groups. The results indicate that telephone groups appear to be a viable option for educating and supporting caregivers in rural areas. In addition, the telephone group participants reported slightly higher satisfaction than the on-site group participants. Perhaps the anonymity provided by the telephone and the convenience of receiving this service at home is beneficial.

Telephone group support provides a cost-effective method of providing support to caregivers who lived outside of an urban center (Brown, 1999). Telephone caregiver groups seem to show that nothing essential is lost in delivering a caregiver support by telephone as opposed to traditional face-to-face participation. Telephone groups, therefore, can bridge the inequities of service for rural residents. The use of telephone technology for groups is a way of providing a specialty help service that is accessible to those who are geographically isolated from urban treatment centers.

In another study, Martindale-Adams (2002) examined the feasibility of telephone support groups as an innovative solution to the difficulties that Alzheimer's caregivers have in meeting face-to-face. In this study, support was viewed as a means for promoting communication by bringing people together who were dealing with same issue. The results indicated that caregivers were extremely or very satisfied with the format of the calls. One interesting finding was that while caregivers did not always feel they were giving support to other participants, they did feel close to group members and were satisfied with the support they received from group members and the group leader. The study revealed that while traditional support groups may function very well as peer led groups, telephone support groups require a leader who is skilled in group process and trained to recognize group process concerns without visual and nonverbal clues. Without this level of facilitation, quieter members may never speak, and individual group members' issues may not be addressed.

Telephone support groups can be an effective mechanism for delivering educational interventions and emotional support to disease caregivers as well as other types of caregivers. Telephone support groups have the potential to expand social networks and, more importantly, expand those networks among caregivers whose care giving demands make them vulnerable to isolation. Martindale-Adams (2002) demonstrated that telephone support groups could be an effective, low-cost alternative to traditional support groups; however, further studies are needed to evaluate the efficacy of this type of intervention among large numbers of caregivers.

Computer-based Support

The last support group method to be discussed is computer-based support. This mode of support can be real-time, on-line (dynamic) with immediate response such as that of a virtual chat room; or off-line (static), such as reading and responding to e-mails or web-based postings. Hsiung (2000) described an on-line self-help group hosted by a mental health professional. This mental health professional focused on maintaining a supportive and protected environment, while the members of the group focused on providing support for each other. The idea was that this strategy would combine the best of both worlds.

In Hsiung's (2000) study, the overall goal of the computer-based system was one of simplicity because many users were computer novices. Posters (threaded discussions) were notified of new messages when they logged on and when they received new e-mail messages. The researcher monitored the postings and deleted inappropriate messages. The system went live in June of 1998, and by January 2000, 1,516 members posted over 21,000 messages in 3,028 discussion threads.

The usage statistics and the anecdotal evidence of the messages (posts) themselves support the effectiveness of this mode of communication (Hsiung, 2000). Drawbacks or negative aspects include the potential for multiple identities and a technical difficulty of effectively preventing determined individuals from gaining at least temporary entry into the group. This hybrid type of group combines the best of the two worlds of self-help (empowerment) and leadership by mental health professional (maintenance of the supportive environment).

In another study, Hollander (2001) looked at the communication needs and practices of those who have survived the loss of a loved one to suicide. While the needs may be different for a cancer patient or family member, the effects of loss and trauma are similar. In this study, Hollander conducted a search of Internet-based survivor suicide Web sites and e-mail lists. During a 9-week period, over 10,000 e-mails were collected. Online interviews were conducted as well as personal e-mail correspondence. This study showed that the need to grieve aloud (via text) is a driving force that goes against the notion that people do not want to talk about death and suicide. In fact, it becomes necessary to find ways to both honor the unforgettable past and move toward a life that incorporates the loss and yet allows engagement with it. Talking to others who are involved in the same process appears nearly indispensable in this task of moving forward. One of the things most often complained of by survivors of suicide and others with grief is how much the rest of the world seems to want them to get over it, to get back to what they were before the loss and to not talk about the loss of the loved one. Hollander's (2001) study showed just the opposite. It seems that computer-based support is an emerging support mechanism that warrants further investigation.

In a study done by Samarel (1998), almost three-quarters of the women surveyed expressed positive changes in their attitudes toward their breast cancer. This is important as women experience a high level of need associated with a diagnosis of cancer (Lindop & Cannon, 2001). In addition, the need for support is not gender specific. Men also require emotional as well as technical support for their illness (Coreil & Behal, 1999).

In summary, if one is physically able to participate in a support group, it may be worthwhile to visit a group one or two times to see if one can benefit. However, note that not all support groups are of the same quality owing to differences in the composition of the group as well as skills and experience of the group facilitator. The only way to know if a support group is of value is to visit a few meetings. Always remember that a support group is not a substitute for sound medical advice.

Spirituality

In order to discuss the relationship between spirituality, religion, and cancer, we first need to define the terms. There is no commonly accepted definition for spirituality

(King, 1997). According to Tillich (1967), there are two types of spirit: one with a lower case "s" and the other with a capital "S". Tillich defined *spirit* as "the life in meanings and values inherent in morality, culture, and religion" and then wrote that *Spirit* "is the presence of what concerns us ultimately, the ground of our being and meaning" (Tillich, p. 9).

Spirituality includes and affirms all experiences in awareness and often is expressed as radiating from an inner source (Vaughan, 1985). Vaughan stated,

> Spirituality presupposes certain qualities of mind, including compassion, gratitude, awareness of a transcendent dimension, and an appreciation for life which brings meaning and purpose to existence. . . . Spirituality is essentially a subjective experience of the sacred. (p. 105)

Perhaps an even broader definition of spirituality is required that encompasses an individual's understanding of and appreciation for the meaning of life. For example, "Spirituality has been defined as an exploration of what is involved in becoming human" (King, 1997, p. 668).

These definitions share common elements such as the making of meaning, the idea of values, and the concept of a higher power. However, these definitions also have their differences and unique emphases. It is for these reasons that it becomes difficult to quantify a person's spirituality. Thus, for each individual the meaning, understanding, appreciation, and definitions of spirituality are unique and special.

As with spirituality, religion also has many definitions. Allport (1967) noted that "religion" is "too broad [a term] for discriminating use" (p. 90), and religious sentiment in every life must take a unique form because each personality is unique (Allport, 1950). In essence, Allport argued that religion varies from person to person.

When used in a healthy way, religion is a tool that leads us to spirit but is not itself spirit (Tillich, 1967, p. 10). In contrast, "unhealthy religion is the state of being enslaved—socially or personally—by a concrete religious system, producing bigotry, fanaticism, inordinate self-destructive ecstasy, dogmatism, ritualism" (Tillich, p. 10). The idea here is that spirit is of God, while religion is of humans.

Many professionals from various fields of study have discussed their beliefs about the apparent connection between spirituality and/or religion and health. For example, Glueck (1988) noted that it is often asserted that those that who are more in touch with the divine are healthier for it. Northrup (1998) discussed the connection she believes exists between a woman's spirituality and her connection with her health. She found higher levels of religious practice were generally associated with better health, regardless of age, and those with more conservative associated religious beliefs exhibited poorer health (Ferraro & Albreacht-Jensen, 1991).

However, in my pilot study, when I asked Micky if her spirituality and religion affected her cancer recovery, she replied that it did not play any significant part. In fact, she stated that she did not attend church for fear of catching something because many sick people attended, and she could not afford to catch anything. In addition, she did not receive communion at home, as all of her images of a priest coming to one's home were of death, and she was not ready for that. Micky's religious and spiritual needs were met through watching evangelists on television and through e-mail correspondence.

Technology

People are living longer and remaining in the work force. As the population ages, members of the work force will face substantial health problems which will negatively impact our society (Pelowski & Berger, 2003). However, these health problems are being addressed in the form of conquering diseases, new and improved vaccines, sophisticated antibiotics, state-of-the-art surgical tools, and the professional use of these tools.

In addition to the technical tools available, the Internet has become a convenient source of medical information for both professionals and patients. In recent years, there has been an increased use of the Internet in the United States by adult patients over the age of 55 (Peterson & Fretz, 2003, p. 452). In addition, Fogel (2004) reported that patients use the Internet as both an informal source of information and for psychological support (p. 5).

What is the Internet? In the late 1960s, the U.S. Defense Department established the Internet as a means for scientists and researchers to stay in contact with one another (Maran, 1995). Eventually, schools, businesses, libraries, and individuals around the world came on-line. In its simplest form, the Internet is a connecting protocol for thousands of individually maintained networks that exchange information and share equipment (Maran, 1995).

Though it appears to have been developed overnight by computer programmers, the Internet was born in the Department of Defense's Cold War projects of the 1950s (Maran, 1995). There is little doubt that the World Wide Web has exploded in popularity over the past few years and will continue to be a dominant source for information in the future. The ability to retrieve information on demand has overcome a major infrastructure hurdle with the wide acceptance of the Transmission Control Protocol/Internet Protocol

(TCP/IP). The Internet has become an efficient tool for retrieving information for both personal and professional use.

According to Zakon (2004), the number of Web site domain names grew from approximately 3,900 in 1989 to over 171,638,297 in January 2003. Furthermore, by April 2001 the number of Web pages was approximately 1,326,920,000, and as of March 2004 that number had grown to over 4,285,199,774 (*WWW FAQS: How Many Web Sites Are There?*, 2004).

This tremendous growth of information accessibility opens the world for people with information needs. The on-line world can be many things to many people, and for someone who is facing a life-threatening illness, the power of the Internet becomes liberating. The Internet, wrote Peterson and Fretz (2003), represents a "revolution in information access for patients . . . and self-education" (pp. 454-455). Ferguson and Frydman (2004) stated that about half of all adult Americans have searched for health information on the Internet. The authors used the term *e-patient*. An e-patient is a person who seeks personal medical online guidance or is a friend or family member searching for medical information on the patient's behalf (p. 1148). There are numerous Web sites for cancer patients and their families that provide up-to-date information about different types of cancers, treatments, aftercare, research findings and virtual support groups (Schultz, Stava, Beck, & Vassilopoulou-Sellin, 2003).

Even though there are numerous resources on the Internet for the heterosexual population, Fikar and Keith (2004) reported that the information needs of gay, lesbian, bisexual, and transgendered (GLBT) professionals, patients, and caregivers are not being met. The authors found no published library or medical information on the information needs of this specific group. While GLBT individuals have the same basic needs as the general population, they also have additional health care and access requirements unique to their special sexualities. Even though GLBT individuals are not easily recognizable by external physical features such as clothing, skin color, mannerisms, and other social markers, they do require GLBT-friendly health resources. Fikar and Keith noted that further research and awareness is required so that the GLBT population can have better access to information to meet their needs.

Although the Internet seems to be a wonderful resource for information at one's fingertips, there is concern about the quality of the information because anyone can construct a Web site (Fogel, 2004, p. 59). As Floridi (1995) stated,

> Because the Internet is a free space, where anybody can post anything, it can easily become a dumping ground for any sort of rubbish, and organized knowledge can easily get corrupted or lost in a sea of junk data. (p. 272)

There is also a danger that the information retrieved is automatically believable. Floridi (1995) said, "we have already entered the stage in which digital information is unduly preferred over non-digital simply because it was available on-line, not because of its quality" (p. 270). However, computer technology is not inherently neutral and if left unchallenged can become a biased source of information. This can be especially harmful for a person searching for medical information. The unstructured nature of the Internet means that both members of the medical profession and the patient can easily fall into the trap of forgetting its intended educational purpose. Thus, one should be cautious about the Internet and all that it has to offer. Challenges remain for health professionals to ensure that there is control over the quality of Internet-based health information (Peterson & Fretz, 2003).

In summary, Northrup (1998) told us that technology is not the total answer; "there exists a powerful medicine when we combine medical science with our hearts and our minds" (p. xxii). A final perspective is offered by Tour de France champion Lance Armstrong: "How much was I a factor in my own survival, and how much was science, and how much a miracle?" (Armstrong & Jenkins, 2000, p. 271).

Symbols

On a continual basis, we use symbols to communicate. These symbols help us to understand the present as well as provide a link to the past. As a person uses and encounters symbols, meanings are derived from these shared understandings of symbols. Lustig (1999) defined a *symbol* as "a word, action, or object that stands for or represents a unit of meaning" (p. 25). By utilizing symbols and their intended meanings, people of the same culture as well as other cultures are able to communicate. However, as Cox (1989) cautioned, one has to be careful when interpreting symbols because "a symbol means to each person something very unique and no one can tell a person exactly what that is" (p. 240).

Symbols can be powerful objects that cause one to have specific thoughts, feelings, and sensations. Examples of powerful symbols include a national flag, a tombstone of a loved one, an Indian headdress, the Star of David, a lighthouse, and a stuffed animal. Symbols such as these and many more are used throughout the world to help people understand and to know one another. These symbols work, wrote Cox (1989), because (a) symbols utilize already accepted beliefs, (b) symbols allow one to identify with one's value base without speaking, (c) symbols do not permit analysis as the meaning is emotional and not intellectual, and (d) symbols transcend time and space (p.

239). In addition, according to Glickman (2003), symbols can also provide comforting assurance, for instance, when one visits a spiritual place or takes a walk through familiar woods. Even though symbols may seem bizarre or strange, the symbol only matters to the person who finds meaning in it.

Symbols have the capacity to divide people as well. Smala (2003) described the war and peace in Northern Ireland and how symbols can polarize people, such as Catholics or Protestants, them or us. These symbols are everywhere and can be signs of reassurance or threat, depending on one's connection and belief in a particular symbol. To illustrate, Smala described the use of barbed wire as something that can be good or bad, depending on which side of the landscape you reside. As a symbol, Smala said that barbed wire stands for "repression, a global symbol for the oppression of freedom, rights, social justice" (p. 41). Wrapping the barbed wire around a burning candle is the symbol used by the human rights organization Amnesty International. In this case, the symbol represents something good.

Jung (1950) explained that we get to know something when we succeed in linking a new perception or thought to something we already know and understand. To further enhance understanding and to facilitate communication, people individually and as a group interpret behaviors and actions. According to Anderson (1984), a person's thought grows through discovery, and it is through discovery that one is able to "discover new things in the world and new ways of looking at the world" (p. 460). However, since communication is an interpretive process, each person can interpret something correctly or incorrectly. For example, an extended arm waving could be a symbol saying "hello" or "goodbye." Since symbols are multi-interpretive, they are prone to misunderstanding and misinterpretation. Another example of a symbol that is frequently misinterpreted is the pentagram. Some believe it is a sacred religious symbol, while others interpret it as an occult symbol. To avoid such misunderstandings, the symbol must be in the proper context, and the interpreter of the symbol must have knowledge of that context.

Besides being difficult to interpret, symbols can also be ambiguous (Cohen, 1979). Writing on the topic of symbolism, Cohen stated that symbolic beliefs have different meanings based upon the culture explored. For example, concerning the question of "why are we born and why do we die?" Cohen wrote that this question is embedded in our human nature (p. 93). There is considerable variation in a society's symbol of death. In some societies, death is the end and the dead are gone forever, while in other societies, the dead continue to live through spirits that continue to interact with the living.

Cultural symbols and the things they represent play an important role in how different cultures ascribe different meanings to these symbols. Kerin (2003) described a field of study called semiotics which "examines the correspondence between symbols and their role in the assignment of meaning for people" (p. 185). Nöth (2003) wrote that semiotics "is the study of signs, and if the study of signs can contribute anything fundamental to the study of pictures, the premise must be valid that pictures are signs" (p. 377). Furthermore, according to one of the founders of the study of signs and symbols, C. S. Peirce, a sign could also be a thought, idea, or mental image (Anderson, 1984). Thus, symbols can become powerful cultural communication tools in that an individual can visualize or imagine a symbol without ever actually seeing it.

According to Buiakas and Zevina (2001), a culture and the symbols within that culture provide a foundation for an individual to develop a base for accomplishing personal tasks. In addition, the authors stated that for a symbol to be fully understood it must be personally experienced and the person must be able to "tell about it in his own language" (p. 61). Buiakas and Zevina concluded that it is only when these conditions are met that a symbol can function as a meaningful symbol in a person's life. Thus, if a person does not interact with a symbol, if the symbol does not become alive in the person's mind, then one has not realized the full meaning and value of the symbol.

In summary, symbols and their attached and interpreted meanings become a part of one's connection to the world. Symbols provide a link to the past as well as signs of hope for the future. By using symbols, we are capable of discovering our own unique world as well as being able to share common bonds with others. Finally, symbols can transform ideas or feelings into tangible things that become part of personal and societal rituals.

Rituals

A ritual is "any practice or pattern of behavior repeated in a prescribed manner reminiscent of religious ritual or an established or prescribed procedure for a religious or other rite" (*Random House College Dictionary*, 1988, p. 1140). A ritual can be an individual act or can involve a group. Examples of individual rituals include the lighting of a candle, saying a prayer, or taking a walk. Group rituals include parades, graduations, and religious services. Troll (1988) wrote that rituals have three components: (1) they involve repetition, (2) they service continuity, and (3) they are relatively more formal than informal (p. 621). According to Rosenthal and Marshall (1988), "A ritual can provide a symbolic connection to the past and to the future . . . and to assist individuals and groups to deal with change without an accompanying sense of disruption or discontinuity" (p. 669). In addition, rituals and their accompanying behaviors and emotions help sustain family connections as well as promote mental and physical well being. These family connections which are facilitated through family rituals can provide security, comfort, and a sense of belonging; and they can lower stress (Fiese, Tomcho, Douglas, Josephs, Poltrock, & Baker, 2002).

Patz (2003) said that it is important to make a distinction between a *ritual* and a *routine*. A routine is a forgettable event that has no emotional weight, such as washing your hair or brushing your teeth; while rituals such as attending a wedding or sharing Thanksgiving "create memories that last" (Patz, p. 140). Fiese et al. (2002) wrote that "any routine has the potential to become a ritual once it moves from an instrumental to a symbolic act" (p. 383). The main difference between a routine and a ritual has to do with the amount of communication, commitment, and continuity. Routines are here and now without much afterthought, while rituals have an "emotional residue" (Fiese et al., 2002, p. 382).

The practice of rituals can be examined from three levels or perspectives: the individual, the family, and society (Troll, 1988). The individual perspective, for example, attending a reunion, can mark a place in time or space; thus one is able to "repeat feelings and thoughts of a past self" (Troll, p. 622). In addition, by recalling the past, a ritual allows people to reevaluate where they have been to better understand where they are today. Finally, an individual perspective gives a sense of continuation into the future, such as when someone says, "See you next year!" Birthdays, graduations, weddings, and funerals provide the opportunity for family and friends to be reconnected with one another.

From the family perspective, rituals, reunions, and rites of passage affirm and strengthen the family structure. They recognize changes in family position, such as when a child becomes an adult and then a parent. Rituals also allow for the transmission of family knowledge and history from one generation to the next. As family members leave the home and set up their own households, thus forming an extended family, family reunions, celebrations, and time to be together become significant family events. Fiese (1993) added that family rituals are unique to each family and may be practiced in various settings. These settings may include mealtime and weekends. In addition, family rituals may also have different dimensions or symbolic significance that affects the meaning of the ritual itself. Thus, the way a family attaches meaning to the ritual is what gives the ritual its affective force (Fiese, 1993, p. 187). However, there is a downside to rituals as they take time and work and can create family conflict (Fiese et al., 2002, p. 383).

Most of the points regarding the family perspective apply to the societal perspective as well. Troll (1988) viewed families and society as similar entities "since families are but particular kinds of societies, distinguished at least in part by lifelong associations and intimate relationships" (p. 629).

Rosenthal and Marshall (1988) conducted a study concerning the diversity, prevalence, and quantity of rituals of families in Canada. In addition, they examined the continuation of family rituals over three generations. The authors noted that the following events were prevalent among the respondents: Christmas, Easter, Thanksgiving, New

Year's, Sunday, birthdays, anniversaries, Mother's Day, Father's Day, picnics, outings other than picnics, vacations, reunions, sports events, graduations, and other special days of the week. Even though the holidays and birthdays were expected to be on the list, outings and picnics were also listed as rituals. These events were on the list because these annual outings allowed for a sharing of common interests and personal interactions, and they were a "symbolic marker of the passing of time and seasons" (Rosenthal & Marshall, 1988, p. 673). The authors mentioned the effect time and change had on the passing on of rituals from one generation to the next. For example, for many respondents, Sunday was a day reserved for family time. However, other respondents mentioned how Sunday was no longer special and became another day for work or shopping. Finally, the authors could not determine from the data if increasing age or life transitions had any effect on the practice of rituals.

The performance of rituals has significant power with regard to family relationships and practices. According to Cheal (1988), family ties are preserved by maintaining personal and family rituals so that individuals feel important and attached to the family. Symbols may also be part of the ritual process that defines the roles of individuals. For example, in marriage, "ritual symbols are used to legitimate the traditional nature of established relationships" (Cheal, pp. 637-638). Rituals become the glue that cements the past with the present and the future. For Cheal, rituals are repetitive acts that are directed toward persons that are highly valued and are part of an ongoing process of constructing and reconstructing intimate ties with one another. In summary, even though these acts become repetitive and they help to support and encourage family ties, they can change over time due to changes in the family structure and take on new or different significance.

Rituals provide opportunities for families to share time and to understand one another as well as the family as a collective unit. Wolin and Bennet (1984) found that rituals provide a window into a family's shared identity and allow access to the unique characteristics of a family. By looking through this window, one can see the message, *this is our family; this is who we are.* Wolin and Bennet concluded that rituals with their special meaning and repetition contribute to the establishment and preservation of a family's identity. This identity becomes a stabilizing force that assists in clarifying expected family member roles as well as in setting family boundaries. Thus, rituals, whether performed individually or within a group, have significant meaning and importance to the individual who is participating.

Not all rituals last forever; one can experience the loss of a ritual. A ritual loss occurs when the ritual no longer has the meaning and significance it once had. In fact, it may become an empty ritual which, if continued can negatively affect the individual and the family.

In conclusion, rituals give order to life. They help us understand and cope with new challenges and major life transitions. It is through the consistency of rituals that one can feel confident that rituals will provide the needed support, both individually and as a group, to manage both the pleasant and unpleasant activities of life.

Work

Many cancer survivors who are physically able to go back to work do so as soon as possible. Being able to work and to have work relationships provides not only financial support but also a sense of self-worth and value (Murphy et al., 1997, p. 346). In addition, Bloch and Prins (2001) stated that "physical and psychological demands associated with a given job or work place determine how good a fit there is between the individual and the work place" (p. 226). Thus, one's physical and psychological abilities affect one's ability to work.

For example, fatigue is a common side effect that occurs during and lingers for some time after treatment. Even though the cancer patient may feel back to normal and up to speed, in reality, this fatigue and resultant lack of work may force coworkers to pick up the slack. Thus, this filling in or covering up may cause resentment and uneasiness among coworkers. In addition, discrimination in the work place may occur, which causes further stress on the returning worker (Lauria, 2001, p. 27). And finally, even though the cancer patient may look the same as before, thinking that the patient is able to pick up where he or she left off underestimates the seriousness of the illness (*Life After Cancer*, 2001).

The American Cancer Society, The National Brain Tumor Foundation, and others offer several strategies for returning to work, such as seeking vocational rehabilitation, participating in support groups, and seeking counseling (Murphy et al., 1997; *Returning to Work After Cancer Treatment*, 2001; *Returning to Work: Strategies for Brain Tumor Patients*, 2001). Some cancer patients with job related problems are protected by federal legislation such as the Rehabilitation Act and the Americans with Disabilities Act of 1990 (Murphy et al., 1997).

Time

Time is a universal language that humans use to convey meanings about lived experiences. Time has been defined as "the system of sequential relations that any event has to any other, as past, present, or future" (*Random House College Dictionary*, 1988, p. 1375). During the early days of civilization, the sun, not clocks, ruled the time in everyday life (Levinson, 2004). As the sun traveled across the sky, one could with the help of a sundial approximate the local time. It was not until the second half of the 19th century that clocks and watches superseded the use of sundials in the United States (Stephens, 2002, p. 25). According to Landes (2000), the greater subject is not how do we measure time, but what are our perceptions and the use of time? (p. xv). To illustrate the span of life from cradle to grave one can imagine an arrow drawn on a sheet of paper. The head, tail, and shaft of the arrow have labels of *past*, *present*, and *future*. Often, these time lines are useful for understanding and appreciating an individual's life span. In addition, time lines help to illustrate and place into perspective historical events. For example, Griffin (2005) presented a historical time line of management from 3000 B.C. through 1500 A.D. This time line begins in 3000 B.C. with the Sumerians and concludes with the Venetians in 1500 A.D. Between those two reference points, Griffin tells us about the historical contributions from the Egyptians, the Romans, the Chinese, and the Greeks (p. 42).

During the early days of the American settlers, religion exerted a powerful influence on the way people spent and kept track of time. Worship, work, and rest were the daily activities. The source of their belief, according to Stephens (2002), lay in the

Bible, which described how God made time, revealed time in nature, and gave time as a gift to humans (p. 39). An old proverb tells us to use time or it will use you.

Benjamin Franklin (1706-1790) asserted that time was money and should not be wasted or squandered. As America became more industrialized and people migrated from the farms to factories, keeping track of one's time became more commonplace. In fact, the time clock now monitored how workers spent their time. In an effort to increase worker productivity, experts such as Frederick Taylor, Frank and Lillian Gilbreth, and Henry Gantt developed and promoted the use of scientific management. As workers ended their work shifts, they would often observe the closure with "happy hour," which symbolized the shift from work time to leisure time (Levinson, 2004, p. 15).

As we move into the 21st century, the boundaries between work time and leisure time seem to disappear. Weekends, which historically have been set aside for family and leisure activities, have turned in to "workends," thus extending the traditional week at work. The words *24 hours a day, seven days a week* written as 24/7 represents a major shift in our expectations from our society, from delivery of online orders, balancing our checkbooks, and refilling prescriptions. Even with the aid of 21st century time management tools, there still never seems to be enough time.

Our 24/7 society, wrote Moore-Ede (1993), has developed because of societal and economic imperatives (p. 7). Those who work during the day expect services at night, and those who work at night expect services during the day. The world has virtually shrunk, and time zones have literally disappeared. Non-stop, continuous activity of people and machines regardless of the time of day is commonplace. This, writes Moore-Ede, is becoming a societal problem. Humans, unlike machines, are not capable of continuous operation. Employees often discuss the need for *down time* and to talk *off line*. In essence, people who work in a high demand, high stress environment find it difficult to unwind after work and remain "psychologically aroused after work" (Cropley & Purvis, 2003, p. 196). Time is not a commodity that can be stored for later use.

Finally, there are health-related issues concerning the use and misuse of one's time, especially in the work place. According to Macdonald (2003), the percentage of people working a standard day has decreased over the past decade, and many workers are working a second job. In addition, Macdonald said that full time employees are working longer hours. The impact of these additional work hours results in accumulated stress that has consistently been associated with stress-related disorders (Cropley & Purvis, 2003). Cropley and Purvis reported that school teachers who are in a high stress environment find it difficult to stop thinking about their work; they think about future work-related issues and think more often about what has happened over the past few days than teachers in low stress environments (p. 196). In addition, the unhealthy practice of extended work hours can lead to severe health problems as well as unhealthy lifestyle behaviors ("Extended-hours workers", 2003, p. 74). Thus, the lack of or misuse of time and the feeling of falling behind adds to one's stress level, which may cause an illness. According to *Harvard Women's Health Watch* ("Three for 2003", 2003), "although stress is never listed among the top 10 causes of death in America, it is linked to many illnesses ("Three for 2003", p. 1). In summary, people need occasional time outs to recharge and to avoid the ill effects of an overloaded time schedule.

CHAPTER 3

METHODOLOGY

As a person living with cancer, I know first hand what it is like to have your body, your mind, your social life, and your spirituality changed and challenged. For this research, I used qualitative inquiry based on grounded theory methodology. This approach has contributed to a better understanding of how a serious life-changing event can affect the lives of higher education teachers. The main reason for choosing the tradition of grounded theory, as opposed to the other traditions of biography, phenomenology, ethnography, and case study (see Creswell, 1998) is that grounded theory is well suited to an area in which there is little or no existing theory. I was guided by the grounded theory approach of Glaser and Strauss (1967) because it is an appropriate strategy when little is known about a certain population. In addition, this study sought to understand the participants in the context of their lives. There have been no studies that have taken into consideration that living with cancer is a highly complex and emotional journey which may be better understood through qualitative research.

> [A theory] is a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena. (Kerlinger [as cited in Gliner & Morgan, 2000, p. 5])

Moustakas (1994) added that "In grounded research the theory is generated through the research process and from the data collected" (p. 4). Silverman (2000) defined *methodology* as "a general approach to studying research topics," while methods are "specific research techniques" (pp. 88-89). Kvale (cited in Warren, 2000) wrote that "the original Greek meaning of the word method 'is a route that leads to the goal'" (p. 86). For this research, the overall goals were to explore and discover the essence and meaning of a serious illness, cancer, on the lives of higher education teachers. According to Merriam (1998), when there is little information about a topic, the qualitative approach is ideally suited. Patton (2002) described three types of qualitative data: interviews, observations, and documents. For this research, I conducted and analyzed data from semi-structured, focused interviews as well as reviewed documents and artifacts from the participants. Many of the interviews involved going out in the field to the participants' office or home to collect rich and thick data (Bogdan & Biklen, 1998; Merriam, 1998). This fieldwork was instrumental in understanding and writing descriptions about the participants' world (Denzin & Lincoln, 2000). In essence, I immersed myself in their world in order to tell their collective stories.

Researcher-Participant

As the primary researcher, often referred to as the human instrument, I was the primary data collector for this study. As the human instrument, I wanted to be at the heart of the research and to be active in the research process by directly interacting with my participants. I was aware of my own biases, preconceived notions, and experiences that may have affected the research process. Since an increased understanding of the phenomenon under investigation is a goal of research, the human instrument is well suited for the task because one can adapt, react, and analyze things as the research develops.

Since the primary data collection is real time, I had to be aware of both verbal and nonverbal communication. However, as Merriam (2002) stated, "the human instrument has shortcomings and biases that might have an impact on the study" (p. 5). Thus, it became important to identify these biases up front and to monitor them through data collection, analysis, and interpretation. However, Tisdell (2002) wrote, "In conducting research, in spite of best attempts to do otherwise, we tend unconsciously to project our own experience or knowledge onto others' stories" (p. 90). I realized that separating the researcher from the research (the observer from the observed) can be challenging, but I believe that my own experiences of cancer and teaching enhanced the study.

I have wanted to be a teacher since meeting my fifth grade teacher, Mr. Roman Cabrera. He was such an inspiration, and he always seemed open to discovering new and fun ways to learn. In spite of his best efforts, I was never a good student, that is, one who earned A's and B's. In fact, that year I probably spent more time in a time-out setting or in the principal's office than in the classroom. After barely getting out of high school in 1970, there were three options available to me: (a) risk being drafted via the lottery system for the Vietnam War (b) get a 2S deferment for college, and (c) hitchhike to Canada. Since I grew up in a military household (my father was a retired army major), option 3 was not a good idea, so from options 1 and 2, I took option 2. Since I had not applied to any colleges during my senior year in high school, through a bit of luck and perseverance I was able to attend a community college. After graduating with an Associate in Arts degree, I transferred to the State University of New York (SUNY) at New Paltz, New York. In June 1974, I graduated with a Bachelor of Science degree in

Education. In addition to my Bachelor's degree, I also earned a New York State elementary school teaching certificate.

After graduation, for the next four months I sailed the east coast moving sailboats from as far south as Annapolis, Maryland to as far north as Rockport, Maine. My last sailing adventure involved sailing a boat to a new buyer in Annapolis. Once the boat was sold, I had to find a new residence. With my teaching certificate in hand, I moved to Georgia in November 1974 to live with my sister and started teaching at an all black elementary school in southeast Atlanta. I taught at this elementary school for five years and during those five years, I was the only white male of three males; the other two were a principal and a custodian. Without being conscious of it at the time, I now realize I developed into Roman Cabrera. However, after five years in the same building, I became stagnant and needed to move on. I resigned my teaching position and went back to college full time to earn my master's degree in elementary education from Georgia State University in Atlanta. After graduation in 1977, I was all set to resume my teaching career but instead decided to join a small, management-consulting firm. This firm offered outstanding pay, opportunities for worldwide travel, and other attractive benefits. At the ripe old age of 27, I decided "what the hell" and took the position as a junior consultant. A colleague said, rather jokingly, that a consultant was a person who was unemployed but always carried a briefcase. Even today, when I meet people and I ask them what they do, and they proudly reply, "Oh, I am a consultant," I say to myself, oh yeah, you are unemployed, too. As a management consultant and educator, I was fortunate to work with companies from various industries, plant sizes, and organizational structures. My travels took me throughout the United States, Puerto Rico, and Europe.

The consulting life was wonderful in spite of the long hours, questionable and often mysterious airline food, misbehaving rental cars, and hotels that were in need of a makeover. Probably most of all, though, I missed my family and friends and the warmth and security of home. Nevertheless, I was in the fast lane of an upcoming yuppie with all its trappings of a twin-engine airplane at my disposal, several nice cars, a home with acreage, and the rest. However, like many things in life, a price had to be paid. The lifestyle I was living took its toll on me. After nine years, I was burned out and worn out, and my body was telling me that not everything was all right.

In November 1988, everything changed when I received a diagnosis of cancer. The proverbial wake-up call had rung, and I immediately answered the phone. It was time to pause and reflect on how I was living. My diagnosis showed that I had a 2.2-pound malignant tumor located between my left lung and my heart. After removal of the tumor and subsequent chemotherapy, I decided to teach again. However, this time, I decided I wanted to teach at the community college level since a majority of my previous consulting work consisted of business- and industry-based education and training. I developed an extensive client list over those consulting years, and I was ready to put that knowledge and experience to use. It took at least six months after the chemotherapy ended before I was strong enough to teach. However, once I was back in the classroom, it was not the same. Even though I may have looked the same on the outside, I knew I was quite different on the inside; but how? This question became the foundation for the present research.

Cancer. It can be a life changing experience and, as one who has experienced it first hand, I wanted to share my own cancer experience but also the stories of other teachers using their own words, feelings, thoughts, hopes, and dreams. I wanted to hear their stories about how they are continuing to be role models for their students, colleagues, friends, and family. In fact, during the summer of 2002, I had a series of meetings with a local college teacher who shared her cancer story with me. Through this research, I was able to test my research methodology and refine my qualitative research skills. Based on the preliminary findings, I felt confident that my research area was in need of further exploration.

Even though a cancer transformation can be a horrible journey, it can also be a positive experience, but only over time. Yes, my own cancer journey has given me a personal bias in what I believe works best for many. I now openly share my experience via various forums, and my oncologist occasionally refers patients who match my diagnosis and treatment for counseling. When people share their experiences with me, I can honestly and with integrity say, “I understand, I know what you mean.” The sharing of stories may have a therapeutic effect.

As stated earlier, I was the primary investigator, the researcher-participant. People who go through cancer experience similar feelings and emotions, but also, each person has unique experiences to share. The data collected was rich, with thick descriptions that revealed the complex emotions associated with a cancer journey. Even though it has been more than 16 years since my diagnosis, I still wanted to share my story as well as the stories of others of how a serious, life changing event like cancer has affected the lives of higher education teachers.

Sample Selection

"Sampling is the process of selecting part of a larger group of participants with the intent of generalizing from the smaller group, called the sample, to the population of the larger group" (Gliner & Morgan, 2000, p. 144). There are two major types or procedures for sampling: probability and non-probability:

> Probability sampling involves the selection of participants in a way that is nonbiased. . . . In nonprobability sampling, there is no way of estimating the probability that each participant has of being included in the sample, thus bias is usually introduced. (Gliner & Morgan, 2000, p. 14)

In qualitative research, we are usually not interested in generalizing in a statistical way; thus, according to Merriam (1998), probabilistic sampling is not the preferred method in qualitative research. However, for qualitative research, nonprobability sampling methods such as quota, purposive, convenience, and snowballing are used (Gliner & Morgan, 2000).

Purposive sampling "allows us to choose a case because it illustrates some feature or process in which we are interested" (Silverman, 2000, p. 104). Strauss and Corbin (1998) recommended using theoretical sampling, which is

> data gathering driven by concepts derived from the evolving theory and based on the concept of making comparisons, whose purpose is to go to places, people, or events that will maximize opportunities to discover variations among concepts to densify the categories in terms of their properties and dimensions. (p. 201)

Theoretical sampling and purposive sampling are often treated as synonyms, stated Silverman (2000), and "the only difference between the two procedures applies when the purpose behind purposive sampling is theoretically defined" (p. 105). Merriam (1998) explained theoretical sampling as an ongoing selection process where the researcher begins with an initial sample relevant to the research and then selects other relevant data sources as the research progresses. Thus, theoretical sampling is an emerging selection process that develops as the theory develops; hence the name theoretical sampling. One problem with this ongoing selection process is that samples may be potentially limitless (Seale, 1999). In other words, one sample may lead to another sample, which would lead to another sample, and so on. The question then becomes, when do I stop sampling? As the research progresses, the sampling becomes more purposeful as the categories become saturated (Strauss & Corbin, 1998, p. 215). Strauss and Corbin (1998) and Glaser and Strauss (1967) recommend stopping when a category has been saturated. *Saturation* means that information is becoming redundant and that nothing new is forthcoming from new samples. Silverman (2000) made the point that "the validity of qualitative analysis depends more on the quality of the analysis than the size of the sample" (p. 42).

For this research, finding participants who met the criteria was a challenge. The participants had to meet five criteria; they must have (1) taught in higher education for at least three years prior to their diagnosis, (2) been located in the metro Atlanta area, (3) been at least one year post-diagnosis, (4) been teaching in higher education either full or part time, and (5) been interested in sharing their story. These criteria satisfied the nature and scope of this study, exploring the meaning of cancer in the lives of higher education teachers, as well as showing concern for the participants.

Participant recruitment was done electronically, using the Internet. I retrieved the names and e-mail addresses of academic deans of colleges and universities located in the metro Atlanta area. All the names retrieved were sent an e-mail (Appendix C) requesting that they forward the e-mail to their faculty. Upon receipt of a response by e-mail or telephone, I e-mailed the Letter of Information (Appendix D) and the Consent Form (Appendix E). In addition, I was open to using my own my personal network and private referrals if needed. As Charmaz (1991) said, "The grounded theory approach fosters following new leads and issues" (p. 276).

Once contact and an agreement were made, I e-mailed a thank you letter (Appendix H) as advocated by Moustakas (1994, p. 177). When an individual wanted to participate but was not selected, I e-mailed a letter thanking that person for his or her interest (Appendix I).

As the primary researcher, I ensured that selected participants met the criteria and had the knowledge required prior to the actual data gathering. The primary selection process took place over the telephone. Upon the initial interview, each participant completed the Consent Form (Appendix E) and the Personal Information Form (Appendix F). All participants received copies of these forms for their records. Throughout the research process, I emphasized the voluntary nature of their participation.

Data Collection

In qualitative research, there are several methods for data collection, including observations, interviewing, and artifact collection (Creswell, 2003). The primary method of data collection for the present study was in-depth, semi-structured interviews. Patton (2002) stated that "we interview people to find out from them those settings we cannot directly observe" (p. 340) and "to find out what is in and on someone else's mind, to gather their stories" (p. 341). The interviewing relationship should become a research partnership between the participant and researcher (Weiss, 1994). According to Seidman (1998) "the root of in-depth interviewing is an interest in understanding the experiences of other people and the meaning they make of that experience" (p.3). The interviews should be a joint product of what we talk about and how we talk to one another. In this regard, the interview should be more of a discussion rather than a traditional interview. The interview guide (Appendix G) was the road map for the interview process. This was essentially the same interview guide that I used with my pilot study approved by the Human Subjects Office at the University of Georgia.

The interviews were digitally recorded for verbatim transcription. Each participant was interviewed up to three times, for approximately one to two hours each time. The initial interview plan called for interviewing all of the participants once, and then approximately one week later, conduct a second series of interviews, and then a third round if necessary. This three interview series is advocated by Seidman (1998, pp. 11-12). As mentioned earlier, participant recruitment was a challenge; thus I had to interview participants as they became available. Many of the participants had prior obligations, so the neat and tidy schedule was not doable. Table 1 depicts the timeline of the interviews.

During the initial interview, after completing the requisite forms, we talked about the first two interview guide questions. During the second interview, we opened with talk about our last conversation and then worked through questions three through five. During these discussions, participants reconstructed their cancer experience and talked about concrete details. In addition, participants reflected on what they had shared to date and described the meaning derived from their experiences. Each interview provided information for each subsequent interview. As the data collection process progressed, I noticed how similar the data were to the data collected during the pilot study. Many of the topics that emerged in the present study had also emerged during the pilot study. As I

Table 1

Timeline of Interviews

May 16, 2003	Mary interview 1, 90 minutes
May 28, 2003	Samantha interview 1, 81 minutes
June 8, 2003	Bill interview 1, 82 minutes
June 11, 2003	Stephanie interview 1, 90 minutes
June 17, 2003	Ronald interview 1, 86 minutes
August 27, 2003	Samantha interview 2, 98 minutes
August 28, 2003	Eddie interview 1, 90 minutes
August 29, 2003	Jennifer interview 1, 72 minutes
September 19, 2003	Valerie interview 1, 99 minutes
September 22, 2003	Eddie interview 2, 94 minutes
September 26, 2003	Bill interview 2, 109 minutes
September 27, 2003	Mary interview 2, 83 minutes
October 3, 2003	Stephanie interview 2, 102 minutes
October 14, 2003	Jennifer interview 2, 54 minutes
October 17, 2003	Valerie interview 2, 98 minutes
October 21, 2003	Eddie interview 3, 112 minutes
October 27, 2003	Jennifer interview 3, 73 minutes
November 4, 2003	Erin interview 1, 93 minutes
November 18, 2003	Erin interview 2, 89 minutes

reflected on the emerging data, I also reflected on the previously collected data. Glaser and Strauss (1967) noted that among other sources, previous research is a potentially valuable data source when using grounded theory.

Prior to a subsequent interview, participants received via e-mail a transcript of the interview for their review and feedback. In addition to the interview guide, a review of the transcripts provided prompts for any additional comments, questions, and new lines of inquiry.

In addition to the in-depth interviews, participants were asked to share any significant personal artifacts that related to their cancer experience. These artifacts were incorporated into our conversations. Artifacts might include photographs, videos, memos, letters, diaries, and memorabilia (Bogdan & Biklen, 1998). As each interview concluded, participants were asked to record any thoughts or questions for later discussion and reflection. As appropriate, these artifacts become part of the research description, analysis, and interpretation.

At the outset, there was an assurance of confidentiality. Since cancer is such a personal issue, precautions were taken to ensure that all discussions remained confidential. Actual names were not used, and each participant selected his or her own pseudonym.

Data Analysis

As stated previously, this study utilized a qualitative research design applying the principles of grounded theory methodology and constant comparative analysis described by Glaser and Strauss (1967). The data were analyzed utilizing the "three concurrent flows" of data reduction, data display, and conclusion as suggested by Miles and

Huberman (1994) and Silverman (2000). With this methodolgy, one does not begin with a theory and then find data to support it. Rather one begins with an area of study and then allows the relevant information about that area to emerge in the collected data. These data emerged from the constant comparative method which, according to Seale (1999),

> is used as a systematic tool for developing and refining theoretical categories and their properties. If applied rigorously, it can aid in taking researchers beyond common-sense reporting of participants' categories so that a study becomes genuinely relevant at a theoretical level. (p. 96)

Patton (2002) added that this approach emphasizes being "sytematic and creative simultaneously" (p. 489). This constant comparison of interview data is what distinquishes interviewing in grounded theory from interviewing in phenomenology (Karim, 2002, p. 47).

The analysis process included an open review of the transcripts to identify emerging concepts and categories followed by an integration of the categories and identification of their properties. The process was not a sequential data collection and analysis procedure, but rather a zig-zag process wherein the researcher goes out to the field to collect more data, then analyzes the data, and then goes back out to collect more data (Creswell, 1998). Data are then compared to previous data, searching for similarities and differences in the various categories. These stages, according to Strauss and Corbin (1998), are referred to as *open coding*, *axial coding*, and *selective coding*. Even though the grounded theory approach may seem overly complex, the process is relatively straightforward because the researcher is doing three interrelated tasks: (a) organizing the data, (b) searching for patterns, and (c) developing ideas and ensuring that the emerging ideas are grounded in the data.

To assist with the analysis and management of the data, NVivo, a computer-assisted qualitative data analysis software (CAQDAS) package produced by QSR International was selected. NVivo was an appropriate tool since its design supports grounded theory methodology. In addition, while NVivo was easy to use, it also had sophisticated features and tools for in-depth analysis. This program facilitated the coding of the data to help develop themes while also allowing retrieval and searching. NVivo was useful for performing constant comparative analysis as an inductive approach to data synthesis and reduction.

I approached the data analysis by reading each transcript in NVivo and attaching codes to a word, words, or sentences. Since the interviews were digitally recorded, it was easy to listen to the interviews on the computer as I read them. Through this additional listening, I would clean up any confusing statements while at the same time make notes on vocal inflections such as anger, tenseness, or humor. After the initial coding, I engaged in a listening iteration process in which I grouped similar codes together. I continued this process until I was convinced that I had adequately covered the three emerging themes. As I encountered data that I thought would be relevant to the study, I asked myself, "What does this relate to?" Through this iterative inquiry process of constant comparison, I converted many broad categories into a few refined categories. This comparison method was so important to Glaser and Strauss (1967) that they described grounded theory as the *constant comparison method*. Even as I wrote my findings, I was still engaged in the comparison of the categories and themes, and it was at this stage that I had an an "aha" moment where everything connected and the theme of time emerged.

Creswell (1998) asked, "How do we know that the qualitative study is believable, accurate, and right?" (p. 193). In response to this question, researchers use trustworthiness procedures to ensure that that the ideas and concepts are grounded in the data. To establish trustworthiness, Lincoln and Guba (cited in Creswell, 1998) used alternative terms such as "credibility, transferability, dependability and confirmability as the naturalist's equivalent for internal validity, external validity, reliability, and objectivity" (p. 197).

In qualitative studies, the researcher establishes the degree of confidence or accuracy in the findings. Creswell (2003) described eight primary strategies that can be used to check the accuracy of the findings. These eight strategies "are organized from those most frequently used and easy to implement to those occasionally used and difficult to implement" (p. 196). Creswell described these eight strategies as follows:

(1) triangulation of data, which means data is collected from various sources such as interviews, documents, and observations;

(2) member-checking which means getting feedback from participants on the accuracy of the researcher's descriptions and themes;

(3) use rich, thick descriptions to describe in detail the settingand shared experiences;

(4) clarify the bias of the researcher so the resulting narrative will be as honest as possible;

(5) present negative or discrepant information which counters or contradicts the themes;

(6) spend prolonged time in the field in order to get an in-depth understanding

of the phenomenom, setting, and people under study;

(7) use peer debriefing which involves having a peer review and ask questions about the study;

(8) use an external auditor to review the entire project, this person is new to the project unlike the peer.

The strategies used in this study to ensure trustworthiness were those that met the requirements for credibility, transferability, dependability, and confirmability. Patton (2002) wrote that "any research strategy ultimately needs credibility to be useful" (p. 51) and that the researcher, qualitative or quantitative, must be neutral in his or her research with no particular axe to grind, theory to prove, or predetermined results to report (p. 51).

Triangulation, member checking, and thick descriptions were used in order to ensure credibility. Transferability was achieved by gathering detailed descriptions of the research methods, participant information, and findings. Dependability was monitored and checked by maintaining a journal of methods used. Any changes to the methods were recorded in my research diary. Finally, confirmability was ensured by using verbatim data and member checking.

Limitations of the Study

Even though grounded theory may be generalized to specific actions and interactions pertaining to a specific phenomenon, explored reproducibility is questionable (Brott & Myers, 2002, p. 150). Since this study used a human instrument and human participants, I am sure there were variations and biases in me as well as the participants. As time passes, it becomes difficult to duplicate conditions, events, and participants. In other words, one can never cross the same river twice. However, understanding and accepting these possible limitations, given similar participants, situations, and research methodology, another researcher should be able to develop a similar theoretical explanation about the phenomena researched. It is assumed in qualitative research that there is no singular truth; thus, findings are subject to other interpretations.

Closing Comment

I received the following e-mail from one of the participants that goes to the heart of my research.

> It has been an interesting process for me too. I have not participated in anything like it and I have tended not to participate in "cancer" activities like "Relay for Life." I don't know why, but this morning as I walked back from an early morning meeting that involved me doing one more job out of the goodness of my heart, I thought that maybe it was cancer which has inspired me to work harder than in the past, but who can say. (Eddie)

It is the last four words, "but who can say," that go to the heart of my initial theory, namely, that higher education teachers who have survived cancer, through that experience, consciously or unconsciously alter their philosophy of teaching and its implementation. I believe this study was a small step in contributing to a broader understanding of the complex issues of maintaining a professional academic life after experiencing cancer. The knowledge gleaned from the individual experiences and personal perceptions are beneficial to teachers, administrators, families, and institutions in order to better assist and understand the personal journey of a cancer survivor.

CHAPTER 4

FINDINGS

In qualitative research, the emphasis is on the meaning people give to their lived experiences. The purpose of this research was to explore the theory that higher education teachers who have survived cancer, through that experience, consciously or unconsciously alter their philosophy of teaching and its implementation. This discussion presents findings from the analysis of the interview data. It should be noted that all personal and proper names used are pseudonyms. This discussion begins with information about the participants and ends with the findings from the individual interviews.

Prior to undertaking the study, a pilot study with two participants was conducted in order to assess the feasibility of continuing with a full-scale study. The findings and discussion about one of the participants is in Appendix A.

The researcher, through inductive analysis processes, used a taxonomy approach to organize the information. These findings revealed three major themes and several sub themes that were common to each participant's respective experiences. The three major themes were (1) the nature of cancer, (2) dealing with cancer, and (3) the outcomes of cancer. Table 2 presents these major themes along with their sub themes.

Table 2

Research Questions, Themes, and Sub Themes

Question 1: What is the essence of the experience of cancer for a higher education teacher? Theme 1 – The Nature of Cancer
Sub theme – Cancer as a Metaphor
Sub theme – Predisposition and Anticipation
Sub theme – Reflections of Causes
Question 2: How has cancer affected higher education teachers' professional lives? Theme 2 – Dealing with Cancer
Sub theme – Coping Strategies
Sub theme – Self Talk
Sub theme – Rituals
Question 3: How do higher education teachers who have experienced cancer describe teaching and learning after they return to the workplace? Theme 3 – The Outcomes of Cancer
Sub theme – Lessons Learned
Sub theme – Perspectives Revised
Sub theme – Teaching and Learning Now

The Participants

The participants in this study were 3 males and 6 females. Another female was interested in participating but died before she could be interviewed. It is fitting and appropriate to honor those people who spent their time, energy, and the giving of themselves. It was certainly a privilege and an honor to be part of their world and to be able to share their stories with others.

The criteria for participating in this study were that each participant had to have been teaching in higher education for at least 3 years prior to his or her diagnosis, was at least one year post diagnosis, and was currently teaching in higher education. An e-mail describing the study was sent to deans of academic affairs of local colleges and universities (Appendix C). Potential participants were asked to contact me directly either by telephone or by e-mail if they were interested in participating. Once contact was made, a confirmation e-mail was sent with a Letter of Information attached (Appendix D). Additionally, a follow up phone call was made to answer any questions about my study and to schedule our first interview. At the initial interview, we reviewed the consent form and any questions were answered. A copy of the signed consent form was provided to each participant. A signed consent form was indication of the participant's interest in being involved with this study. Based on the number of college and universities that were e-mailed initially, I believed that recruiting participants would not be a problem. In fact, I thought I would be overwhelmed by responses and would have to turn people away. Nothing could be further from the truth. When I shared my frustration with Valerie, one of my participants, she said, "I am not surprised at all. Either they have died or they have moved on."

The participants' viewpoints and observations varied in terms of perceived causes of their illness, cancer type, amount of time since diagnosis, and treatment received. In addition, all participants underwent conventional treatments for cancer including surgery, chemotherapy, and radiation. Several of the participants also used Complementary and Alternative Medicine (CAM) as well as nontraditional treatments including meditation, visualization, crystals, prayer, nutritional supplements, and herbs. Several of the participants consulted with and participated with non-medical practitioners such as herbalists and naturopathic healers.

The teaching experience of these educators ranged from 6 to 30 years with a combined total of 156 years. Two participants held Doctorates of Education (Ed.D.), three held Doctorates of Philosophy (Ph.D.), one held a Master's in Divinity (M.Div.), one held a Doctorate of Arts (D.A.), and one held a Doctor of Medicine (M.D.). Areas of teaching included Adult Education, Science Education, Christian Education, English Education, Psychology, Public Health, and Genetics. The years teaching prior to diagnosis ranged from 3 to 28 years with a total of 114 years. The number of teaching years since diagnosis ranged from 2 to 20 years with a total of 43 years. The age at diagnosis ranged from 33 to 60 years. Types of cancer diagnosed included prostate (Bill), thyroid (Eddie and Ronald), breast (Erin, Mary, and Stephanie), colon (Jennifer), and ovarian (Valerie). The current health status of the participants ranged from good to excellent. The ages of the participants at the time of the data gathering ranged from 48 to 65 years.

The ninth person, Samantha, another higher education teacher with over 25 years of teaching experience, is included in this study even though she did not have cancer.

When I received the following e-mail message, I knew I wanted to talk with her. "Hank, if you want to talk with someone whose life has been turned upside down by cancer, I am your person." I learned that her younger sister Sonya had died two years earlier. Samantha wanted to share her story about how Sonya's cancer experience and ultimate death had affected her own teaching and professional life. Samantha is important to this study because her experiences reinforce the far-reaching and profound effects that cancer can have on individuals who are close to the cancer victim. The effects discussed by Samantha were similar to those discussed by the other participants. Information about the participants appears in Table 3.

Nineteen interviews were conducted and took place at either my home or the participant's home or office. One of the interviews started at a participant's home and then we concluded at a nearby coffee shop. The interviews were digitally recorded, transcribed verbatim, and saved as Rich Text Format (RTF) documents. These documents were then loaded into NVivo in order to take a qualitative look at qualitative data.

Data Analysis and Interpretation

Data collection, analysis, and interpretation occurred simultaneously throughout the study. Grounded theory methodology involves three levels of coding or annotating to identify topics, themes, and issues. The three levels are *open coding*, *axial coding*, and *selective coding*. Open coding involves generating categories or codes from the data. NVivo refers to codes as nodes that represent containers for one's thoughts or ideas about the data. I used two types of nodes: (1) in vivo nodes, which are the actual words of the participants; and (2) nodes that represent thoughts developed by the researcher. These

Table 3

Participant Information

	Bill	Eddie	Erin	Jennifer	Mary	Ronald	Stephanie	Valerie
Age At Diagnosis	50	44	44	33	59	56	51	60
Diagnosis	Prostate	Thyroid	Breast	Colon	Breast	Thyroid	Breast	Ovarian
Current Age	51	48	49	54	61	62	54	65
Current Health Status	Good	Good	Excellent	Good	Good	Excellent	Excellent	Excellent
Highest Degree Earned	Ed.D.	Ph.D.	M.Div.	D.A.	Ph.D.	M.D.	Ed.D.	Ph.D.
Teaching Field	Adult Ed	Science Ed	Christian Ed	English Ed	Psychology	Public Health	English Ed	Genetics
Years Teaching in Higher Education	20	17	7	30	30	6	19	27
Years Teaching Prior to Diagnosis	18	14	3	10	28	3	16	22
Years Teaching Since Diagnosis	2	3	4	20	3	3	3	5

Gender: 3 males and 5 females; Average age at diagnosis: 50; Average age at time of study: 56
Current minimum age: 48; Current maximum age: 65
Total years teaching experience: 156
Total years teaching experience prior to diagnosis: 114
Total years teaching since diagnosis: 43

Note:
Samantha (Ninth participant, Current age 53, Ed.D., Special Ed, Years teaching in Higher Education: 28).

nodes derived directly from analyzing the data. As I worked with the data, I continued to code until I felt as though I had covered the most important ideas (see Appendix J). Through axial coding, which is an exploration of the relationship among categories; I then examined the causes, conditions, and actions that revolved around the cancer diagnosis. This examination led to the development of a hierarchy of nodes, NVivo refers to these as tree nodes (see Appendix K). Lastly, through selective coding, which is the process of selecting the major phenomena of the data, I tied everything together to get to the main question of my research: How does cancer affect the lives of higher educational professionals?

Discussion of Major Findings

The discussion will focus on the three major themes: (1) the nature of cancer, (2) dealing with cancer, and (3) the outcomes of cancer. These themes will have support from the literature, the participants, and me. In addition, each major theme will have three sub themes that provide additional support.

Theme 1 – The Nature of Cancer

The American Cancer Society defines *cancer* as "a group of diseases characterized by uncontrolled growth and spread of abnormal cells. If this spread is not controlled, the result can be death" (*Cancer Facts & Figures 2004*, 2004, p. 1). Cancer afflicts people of all ages; however, the risk of cancer increases as one gets older. Many people believe that cancer is caused by factors that are considered internal or within one's control as well as by factors that are external or out of one's control. Examples of internal factors include genetics or family history, one's own immune system, and self-imposed stressors. External factors include tobacco use, chemicals, and the environment.

During the initial interview, the focus was on individual diagnosis, prognosis, and cancer discovery. In addition, details were ascertained from the participants, such as where were they, who was with them, who did they talk to first, and when they received the diagnosis. In essence, the participants were to share their cancer story so I could begin to understand their journey, or as Kleinman (1988) called it, the *illness narrative*. For Kleinman, this narrative or story allows one to share the meaning of an illness from the patient's frame of reference. In other words, what does each person's story reveal about that person and the world in which that person lives? It is important to understand what the illness means to the sick person as well as what the impact of the illness is on members of the family and to society as a whole.

When a person receives a cancer diagnosis, his or her world has come to a sudden stop. Life is not going to go as planned, at least not for the immediate future. A cancer diagnosis creates a significant divide between today and tomorrow. It is the worst of times because victims know they have cancer but they do not have a plan. Even though one may feel overwhelmed with emotions, information, and responsibilities, it is important to learn as much as possible about how one's cancer is living and growing as well as what one can and should do about it. One faces important decisions concerning medical treatment, employment, and life at home. My own personal journey was like entering an enormous forest at night with neither a map nor a lamp to guide me. There were several different paths to take; some were well traveled, while others were uncharted. The initial question for a victim of cancer becomes, "Which path do I take?" Does one follow the conventional path of surgery, chemotherapy, and radiation or take the path lightly traveled? As you will discover, each of the participants had memorable journeys.

Bill

Bill was 50 years old when he was diagnosed with prostate cancer. He was one-year post diagnosis when we first talked. He lives in the suburbs of a southeastern town with his partner Peter and his extremely friendly dog named Tony. Tony always greeted me with a welcoming smile as if I were part of the family. Bill, his owner, treated me the same way. Even though we had only talked once on the phone before our first interview, I instantly felt a special bond when we shook hands for the first time. Perhaps since we were both cancer survivors and had traveled the cancer path, a common experience bond was already established.

On my initial visit, Bill gave me a tour of his family room, which was decorated with artifacts and paintings collected during his frequent travels throughout the world. From the family room, we went in to the kitchen where I set up my recording equipment on the kitchen table while Bill prepared coffee. Once the coffee was ready, we settled down facing one another. To open things up, I asked Bill to tell me about his hobbies, any spiritual beliefs, and current health status. He shared that he loves to visit the Southwest and loves the Native American culture and its heritage. In fact, he said he has considered moving to the Southwest if he could find an appropriate faculty position. Running, weight lifting, and mountain biking to stay in shape have become a daily part of Bill's life. He said that doing these activities has become a priority since his diagnosis and treatment. He believes that there is a strong connection between a healthy body and a healthy mind.

Bill was raised Roman Catholic but says that his spirituality is now more earth-centered, which he says is characterized by having a deep appreciation that there is something bigger, transcendent, other than the (in comparison) smaller mundane things of his day-to-day existence. He feels that his current health status is good and views himself as a survivor—not only a cancer survivor, but also a survivor of life.

Bill had always had relatively good health and was a bit surprised when the results of his annual physical showed that his prostate was a bit lopsided. Initially his doctor told him that it was probably nothing, but he said, at your age with a little asymmetry, it is best to have a Prostate-Specific Antigen (PSA) test. A PSA test is designed to measure the prostate-specific antigen levels in a male's bloodstream. Even though this test may be able to find prostate cancers in their early stages, it is still considered controversial because it is not yet known if the process actually saves lives. Bill's PSA came back at 4.2, which is 0.2 above the limit. However, Bill shared that he was not overly concerned with the test results being over by only 0.2, since as an educated and trained researcher, he figured that there must be some sort of experimental variable in there, somewhere. So what was the big deal? However, after talking with his doctor Bill agreed to undergo a six-point biopsy. The exam revealed that three of the six sites were cancerous and the other three were precancerous, which meant that Bill definitely had prostate cancer. So how does one react to a diagnosis of cancer?

> I was probably functioning, when he told me this, a little bit on autopilot. You know, there was this awareness that . . . okay, I understand what he has told me, but I'm not sure that I'm allowing myself to feel the full impact of what that might mean. (Bill)

In Bill's case, functioning on autopilot allowed him the presence of mind to contact his loved ones right away, first his companion and then his sister. His behaviors illustrate that the body is a marvelous machine that seems to have built-in systems to help one get through horrendous moments of shock and disbelief. For Bill, talking about things, bringing things out into the open, not hiding them or denying them, is his way of having control. He used the term *sunshining*, saying the best antiseptic for anything is sunshine. I was curious about this sunshining thing, so I probed. In general, people are reluctant to talk about situations that make them feel uncomfortable or awkward. With Bill's diagnosis, he wanted people to know that he had cancer and so he was open about it and did not want any misinformation. For Bill, sunshine and fresh air are the greatest antiseptics for any kind of social, cultural, political, or personal ills. Using this metaphor, it becomes important to provide accurate information and not misinformation because the rumor mill is much worse than the truth.

Bill's attitude necessitates having an open dialogue with life. I believe that this type of dialogue better prepares one for the numerous unanticipated disruptive moments that one faces in life. Instead of viewing life at a distance with a telescope, a microscope is used. No longer should important and difficult issues remain sequestered in one's secret hiding spot, but should come out into full view. They need to be full of light, like a highway billboard sign, so they no longer sit in silence and darkness along the highway of life. For many, maintaining silence and hiding in the dark becomes a way of life that has detrimental, long-term effects on a person's health. For Bill, talking about his cancer is a worthwhile and healthy discussion to have both inside and outside of the classroom:

> You know, it was that toss up between do you let people know, 'cause they want . . . they think you want pity. . . . I consider myself a cancer survivor and that's

> something that as an educator, I want to talk about and it helps me through it, too. I mean it helps me deal with it and I think it's very valuable for others, too. That cancer is a survivable disease and it's something that I encourage people to talk about. It's amazing the number of cancer survivors that I encounter as we are everywhere, and so that's a good feeling. (Bill)

Of course, there may be times when not bringing things immediately to the surface may become important and necessary because one may need some time for reflection and self-talk. In my own case, I imagine a body of water surrounded on all sides by land where there are no outlets for draining the old water and no inlets for fresh water. To avoid both mental and physical stagnation and despair, digging inlet and outlet trenches allows water to flow just as the creation and maintenance of relationships allows human sharing and healing to occur.

Eddie

Eddie was 44 years old at the time of his thyroid cancer diagnosis. He lives in the country with his wife Linda; assorted farm animals including chickens, hens, and roosters; and his dog George. When we first talked, he was three years post diagnosis and in good health. However, by the time of our third and last interview he was scheduling additional surgery on his throat. It seemed that his cancer had resurfaced. This last interview was quite different from the others, as he now had to consider how his upcoming surgery might affect his ability to speak. Since verbal communication is a dominant mode of communication for many teachers, what would be the impact on his teaching if he were not able to speak? How would the loss of his voice affect his teaching and his life? How would he continue teaching if his verbal communication disappeared? How devastating it must have been for Eddie to hear this news. By the time this interview wound down, there was a noticeable change toward sadness in his demeanor. As I packed up my things, Eddie stood up as usual to shake hands and to say good-bye, but this time it was different: I hugged him. I know he was surprised by this and in a comforting voice, I said to him, “I am not sure if you are a hugger or not, but every cancer survivor I have ever met is.” I do not remember who stopped hugging first.

Eddie had been a science professor for over 14 years and was actively involved in ongoing science research, especially in the area of biology and its impact on the environment. When I first met Eddie at his campus office, he greeted me with a warm handshake and a smile. I was not sure what to expect from a science professor; would our talk be filled with technical jargon associated with biology and phrases foreign to me, or would we have down home, country discussions? Much to my delight, Eddie was eager to share his reflections and thoughtful insights about his cancer experiences.

Eddie’s tiny and dimly lit cramped office was overflowing with technical journals, test equipment, and an assortment of old calendars. I could not help but wonder—as I scanned his office walls for the first time—about the significance of these calendars. It was not until our second interview that Eddie said that these calendars represented and reminded him of significant events in his life. A couple of the calendars were fishing calendars that had pictures of places where he had fished. Other calendars were gifts from friends, which had days already circled to remind him of birthdays, anniversaries, and other happy events. However, there was a business-scheduling calendar next to his computer. This calendar, he said, contained a chronology of his cancer experience, from the day he received his initial diagnosis right up to his next hospital visit. These calendars were his way of keeping track of significant events, both happy and sad.

Eddie was born and raised in the South and enjoyed reading and writing about southern history, especially events surrounding the Civil War. I always looked forward to talking with him because he had wonderful stories to share about teaching and, how in life, everything seems to happen because of something else that happened just before—not just the big things, but little things as well. This I believed was the biologist/scientist in him talking. He did not believe that there is any predetermined course for one's life, there is no master plan; rather, whatever we do influences what will come next. In fact, his views on life influence his religious beliefs, which are nil. Eddie does not believe that we are guided or watched over by any supreme power or authority. This was certainly an area that I wanted to explore; Eddie's belief was contrary to what I heard from other participants. In fact, several participants said it was their faith in a higher power that both sustained them and helped them get well.

Eddie was in his doctor's office for removal of a cyst on his neck when his doctor told him he had papillary thyroid carcinoma. What was supposed to be routine surgery and no big deal became a big deal: Eddie had a complete removal of his thyroid and 27 lymph nodes from his neck.

> I had a cyst on my neck, and nobody thought that was a big deal, and even after the surgery no one thought it was a big deal. It was only after the pathological studies of the tissue that was removed showed the tumor that anybody was alarmed. (Eddie)

Even after receiving his diagnosis, Eddie was somewhat nonchalant, saying to his friend, "Well, you know, it didn't come out quite as good as we had hoped." Perhaps this was his way of making sense of it, like Bill, running on autopilot and thinking, there must be a solution if we apply all of the marvels of modern scientific tools and techniques, so let us keep on working.

> I've had them tell me things, and . . . before I was a cancer patient myself I envisioned that life with cancer was different than what it turned out to be for me once I had it. I guess I had envisioned that once the doctor gives you the fatal . . . they say those words to you that there's never a minute's rest, you know, that you're thinking about that. It's not like that for me. (Eddie)

It was obvious that Eddie was looking forward to his continued research, his work with graduate students, and taking care of his wife and home. He was not about to let something like cancer interfere with his future.

Ronald

Ronald was 56 years old at the time of his diagnosis of thyroid cancer. He was 62 years old when we met and he said that he was in excellent health. He was a researcher in the field of public health and had been teaching in this area for the past three years. He and his wife lived in the city and had three grown children. Besides his work, he enjoyed gardening, spending time at their lake home, travel in the United States and overseas, and working with his students. Six years ago, Ronald made a career change from working for a government agency that had a time clock to teaching, where "it's your own time clock" that primarily drives things. "If I want to go plant flowers or play golf, which I am not into, I could."

Even though I interviewed Ronald only once, at this office on the third floor of a modern medical research facility, he was a pleasure to talk with. Laughter and smiles accompanied his speech. It seemed as though he was enjoying the opportunity to share his cancer story as well as to share where he was right now in his life. The conversation flowed from topic to topic and required little probing on my part. When I asked him about his specific cancer and if there were any direct effects, he replied,

> Well it led to a job change for me, which in fact took a tremendous amount of stress off my mind, 'cause I was working too damned hard. I was working too

> hard and getting too little professional reward from the supervisor, if you will, in the system. (Ronald)

Since Ronald was an M.D., I wanted to know from a medical expert if he believed there was a connection between one's occupation or environment and getting an illness. Sapolsky (1998) said that "it is more accurate to say that chronic or repeated stressors can potentially make you sick" (p. 16). Thus, it is not the stress that makes you sick but rather, that stress compromises your immune system. This in turn increases the risk of getting a disease that eventually can make you sick. While Ronald spoke proudly about the professional rewards of his work, he also was adamant about the numerous work- and home-related stressors that might have accelerated his getting cancer.

> I suppose I could argue I needed cancer in my life to get out of that job. I would've been out of it anyway. It was just [laughs] a matter of time and it may have helped move things faster. It was a year with a lot of stressful events. My father-in-law dying, my wife's illness, and then my cancer. We were sort of sequencing who needs the most critical care at this point in time and then moving on to the next person. (Ronald)

Concerning his cancer diagnosis, Ronald said that he was fortunate to get one of the "good cancers." A good cancer is one that has a high cure rate; however, like many cancers, it can reoccur several years later. As a medical doctor, he said that he should have been more aware of the symptoms and signs that something was just not right. Ronald's attitude was similar to Eddie's that yes, something was not right, but it was probably no big deal. It was just by chance that when Ronald was walking on the shore at his lake house he happened to step on a fishbone. He thought his foot would be okay but it soon became infected so he visited his family doctor. Since it was almost time for his annual physical, his doctor suggested that while they take care of his foot, why not do the physical at the same time. It was during his exam that his doctor noticed that Ronald had an enlarged thyroid. Not wanting to take any chances, his doctor scheduled a needle biopsy. The biopsy confirmed that it was cancer and within three months, Ronald underwent thyroid surgery followed by chemical treatments.

Like others in this study, Ronald was annoyed with himself because he knew that something was not quite right. For the past few months he had had difficulty swallowing but he did not do anything about it because he said he was too busy. Working more than 60 hours a week does not leave much time for anything, let alone making appoints with doctors. However, as he reflected on the enlarged thyroid, he said, "It didn't take a clinician to tell me. It would have just taken a little observation on my part."

As we talked about changing perspectives on life, Ronald said it was difficult to determine whether or not his cancer had any effect on how he was living his life now or was it a matter of just getting older. He said that all of us are viewing life differently now than we were 30 years ago and we are just at different stages. He laughingly told me that he has planted "a hell of a lot" more flowers in the last three years than in the past 30 years. However, he thought that this may have been due to his job change and not his cancer.

Ronald repeated that his cancer was a minor blip on the radar screen and recalled that as he was being wheeled out from surgery the first thing he requested from his wife was a telephone so he could phone his office and see how things were going. However, his wife said he behaved like a sheep on its way to slaughter. Again, with his smiling voice, he said, what will happen will happen, as life stops for no one. He believed that with good surgical procedures and proper follow-up, everything should be fine. His main concern was a possible complication from the surgery, which might affect his voice box.

Of course, loss of his voice box would make speech difficult, but he believed that was a remote possibility.

Some cancer survivors are able to put their cancer in the background, while for others it is always in the foreground. This is based on several factors such as the type and location of the cancer, what surgery was performed, the intensity and duration of the treatment, and the prognosis. Even though Ronald's diagnosis was in 1996, only eight years ago, he found it difficult to remember many of the details of his cancer. In fact, during his most recent annual physical exam, his doctor asked him about his cancer and Ronald's reply was, "I don't know." Ronald takes his medicine as if he were taking a cold pill. He said, "You know having had cancer one looks maybe a little more seriously at what is important but really it has not changed my life." However, he did talk about the chemical treatments and the affect they had on his physical and mental capabilities:

> Well in the short term it's an incredible dumbing down experience. I mean you speak with a slower, deeper voice. You have trouble doing anything mentally or physically. It's like someone took 40 points off your IQ abruptly. I mean [laughs] you're off your physical ability to do anything. It was an educational experience, but not one I'd recommend to anyone to go through it [laughs], but it also makes you, it's like with anything, if you've experience a diseased or a health problem, you're a lot more empathetic to people who have it and might have it from birth. (Ronald)

Ronald said his treatments transformed him into a completely different person. He likened his behavior to the "walking dead." Cancer has a unique ability to fast-forward a person's appreciation for life as well as an appreciation for others.

Erin

Erin was 44 years old at the time of her diagnosis with breast cancer. She was 49 years old when we first met. She told me that in spite of several intense surgeries including a mastectomy and reconstruction, chemotherapy, and radiation, she is in excellent health. Her love for life was evident in her numerous spiritual paintings and drawings on her office walls. Even when she spoke, there was this "bubbliness" in her voice and eyes. Imagine a young, energetic, high school cheerleader. That was Erin, ready to cheer the team on to victory. She believed that with extra effort and a strong faith, positive outcomes are possible.

Erin is married and has three children, one in elementary school, one in high school, and one in college. She lives in the metro area with her husband and her son. Her teaching area of expertise is theology and Christian education. She has been teaching for a total of 7 years, and it has been 4 years since her diagnosis and treatment.

When Erin and I first talked on the phone, she told me that had we talked a year earlier she would not have participated in this study, as the cancer experience was still too fresh. However, things were different now, and she was ready to share her story, not only to help herself, but to help others as well.

Many people do not want to share their cancer experience because they believe that their cancer was something they did to themselves, that it was some sort of punishment for leading a bad life. They do not want anyone to know about it; they just want to get through treatment and get back to life. However, Erin knew that the act of sharing helps heal the physical, the mental, and the spiritual. Erin was committed to her faith and found both strength and comfort in her religious beliefs. In fact, throughout her cancer experience, she intensified her love for God. In addition, she continued to make herself available to talk with others about her cancer experience. As Bill told us earlier, we cancer survivors are everywhere.

During our initial interview, Erin wanted to know about my cancer experience and the background for the study. My story was complete but brief as I was there to learn as much as I could about her cancer discovery and initial reactions. She explained that she was out of town for a few days and when she returned home, her youngest son, who was 7 years old at the time, ran to greet her and he ran right into her chest.

At first, Erin thought that he may have bruised her rib cage, but after rubbing on her breast area, she realized that that area was tender. She thought to herself, "Could a bump from her son cause such soreness?" She decided to ignore this soreness, hoping that it would "go away on its own"; and anyway, she was due for her annual check up in two months, so what is the rush? However, after a month, the tenderness was still there. She called her doctor and said, "I would like to come in now for my check up." Everything was okay except for the tenderness. Her doctor scheduled a mammogram and ultrasound examination. The technologist said there was "nothing there." However, Erin insisted that there was "something there" but again the technologist told her that it was just a bruised rib and nothing was showing up.

A day later her doctor called after reviewing both the mammogram and an ultrasound and said "Let's just watch it and wait a year and we'll check and see if it's done anything between now and then or you can let me know if it does." At that time, Erin was okay with that conversation, but after a week, she decided to see an internist, a person that she had known and trusted. She told the internist about the reports and what her doctor had told her about waiting a year and his reply was, "Let me just tell you, if you were my wife, I wouldn't want you to watch it and wait a year. I'd want you to see somebody." This doctor evidently believes that the best place to watch a tissue sample is in a jar of formaldehyde. Heeding this advice, Erin went to see a breast surgeon who told her, "We do not mess around with things like this. You know, we're not gonna watch this. We're not gonna wait. We're gonna see what we can find out now."

The surgeon performed a needle biopsy and made several attempts to a get a good sample, but the samples were inconclusive for cancer. In order to arrive at a conclusive diagnosis, a removal of a section of her breast was necessary. This sample confirmed that it was cancer. Erin underwent additional surgery to include a complete mastectomy and reconstruction. Once she was physically able, she had six months of chemotherapy. Like many others, she debated about having radiation, but in the final analysis, she believed that the more one does immediately after surgery, the better one's chances of arresting the disease. Thus, once her chemotherapy was through, as "additional insurance" she underwent six weeks of radiation.

Erin epitomized the survival and sharing spirit. Not only did she have the ability to hang in there and keep doing what she needed to do for herself; she also was able to help others. During her chemical treatments, she made an intentional effort to minister to the people around her. She saw herself as a person who could help others by relieving their anxiety by helping them talk through confusing and difficult issues.

Mary

Mary was 59 years old when she received her breast cancer diagnosis. She was two years post-diagnosis when we first talked. When asked about her health status, she replied that she had no evidence of disease, also known by cancer patients as NED. However, she said she was probably borderline on many other things and that was why she wanted to get healthy again. She laughed when she said that her mental health was probably worse than her physical health. Mary was raised Jewish but does not faithfully practice her religion. Instead, her spiritual life, as she explained it, is to approach healing, both physically and mentally, from a holistic perspective. This holistic approach included a new look at nutrition, exercise, alternative therapies, and relaxation techniques. Mary was devoting a significant amount of time researching and putting in to her own life the holistic approach.

Mary was a widow after being married for over 30 years. Her husband died in a tragic car accident three years prior to her cancer diagnosis. She and her husband did everything together, and to her, getting cancer was her way out of this life.

> I really was not interested in continuing, and I think the whole cancer thing was a burden. The concept of death was not at all bothersome to me. And as I say, I really did say well maybe this is my way out, you know. And I wasn't in any kind of pain or anything, or, you know, physical pain and just trying to make decisions. (Mary)

It seemed that the stress of her losing her husband so tragically and quickly was too much to accept and left Mary with too many decisions to make on her own. From a medical perspective, Sapolsky (1998) said that a person with fewer social relationships has a shorter life expectancy. Protective relationships such as marriage and group involvement can increase one's immune system. The process of losing a loved one and the ensuing social isolation is associated with a lower immune system, providing a fertile breeding ground for a disease. Mary experienced an extreme form of social isolation: becoming the one left behind, in other words, the grieving spouse. She was not, at the time, interested in becoming the one left behind and was almost appreciative that she had cancer so she could leave this life. Life without her husband was not worth living.

The first interview took place at my home and the second took place at Mary's home. When Mary knocked on the door and I welcomed her inside, I immediately felt comfortable with her. She had an unassuming air about her, as though we had known each other for a long time, much like when a fond relative comes to drop by from out of town just to say hello. Her warmth was immediate and contagious. Perhaps it was her clothing, a colorful t-shirt, baggy walking shorts and sandals that made the difference. Certainly, this was not the attire I visualized from a seasoned, 30-plus year psychology professor. Two words sum up Mary: free spirit.

As soon as Mary got comfortable, she began to talk about her academic career, her cancer diagnosis, and treatment. She was so easy to talk with, like talking to one's favorite aunt. Right away, I said to myself, this is going to be a wonderful interview, and it was. We progressed from question to question, topic to topic without any awkward or dry moments. The interview lasted almost two hours, and I am sure we could have talked longer, but it was getting late.

As with the other interviewees, I asked Mary to share her story about how she found out she had cancer and then her treatment. Like so many others, she had an idea that something was wrong but denied that it was anything serious or of concern. She had this lump in her left breast but figured it was nothing since her mother had the same sort of lumps several years ago. In her mother's case, the lumps were benign and surgery took care of them. However, Mary's lumps had come and gone over the years, but this lump was different; it was staying. Again, she did not think that it was anything of major concern. Besides, over the years, like clockwork, Mary had her annual mammograms and sonograms with no abnormalities. This time when she went in for the mammogram, it was different. The lump was circumscribed, oval, and dark. It was obvious to Mary that this lump was indeed different, and she remembers saying to a medical staff person, “You don’t have to be a rocket scientist to see a difference.” The staff agreed that it looked suspicious and said they would be in touch.

When Mary got home, she called her friend who had had ovarian cancer several years earlier and immediately got the names of three doctors. She then made appointments with all of them. The first doctor examined her and said that the lump was probably benign, but it was massive and needed to come out. He also suggested she have a mastectomy. Thank goodness, she thought, I have two more doctors to visit. The next morning was another appointment, another long wait to see the doctor, and the same diagnosis and recommendation. When she got into her car, she broke down and said to herself, “How am I going to get through this without my husband? Will tomorrow be any different?”

The next day was different in three ways. One, the doctor was a female, which made Mary feel more comfortable. Two, the nurse gave her a cotton gown and not a paper one to wear so Mary never felt undressed while being examined. Three, the doctor said, “I’m concerned and you need to have a biopsy; you don’t have to do it yesterday, but be sure to make an appointment before you leave.” That was it. Mary had found her medical partner.

Even though Mary had found her medical partner, was she doing the right thing?

> So it was, you know, it was two things. It was not having him there to talk with and the whole thing with the chemo . . . and that if I did anything more conventional than surgery, that I was betraying him and our beliefs and everything. And literally all I wanted to do was get into bed, pull a blanket over my head and that’s what I did. (Mary)

After the biopsy, Mary had the lump removed along with several lymph nodes. Chemotherapy and then radiation treatments followed her surgery. Even though she now feels she made the right decisions, she occasionally struggles with those decisions.

Stephanie

Stephanie was 51 years old when she received her breast cancer diagnosis. She was 53 years old when we first met at her campus office. Stephanie taught English Education for 16 years prior to her diagnosis and was three years post-diagnosis. She lives in the country with her husband, a retired civil service engineer, and their two cats. Her current health status is excellent. Her religious affiliation is Presbyterian. Stephanie's religion was a constant companion to her during our conversations, and at the start of our second interview, she gave me a page from a book of daily prayers dated Friday, October 3, 2003, God of Light. The passage was from Psalm 139: 1-12 (Revised Standard Version): *Even darkness is not dark for you, and the night is as bright as the day.* The story was about a person's reaction to receiving a cancer diagnosis, much like hers, and concluded with, *And God invites us to share the experience of being led out of the darkness into the light of life!* As I thanked her for this story, I could tell that she was full of emotion as she said, "Sharing my story makes my darkness more beautiful every day." Stephanie was certainly one beautiful person.

Unfortunately, being a beautiful person does not prevent one from the annoyances and frustrations of the medical community. Stephanie's ordeal was similar to Mary's; her first and second diagnoses were from male doctors, and she did not feel comfortable with either one. Stephanie's third diagnosis was from a female doctor, and the connection was immediate:

> The minute I met her, there was no discussion. I knew that was what I want. I don't care if she was gonna cut my head off, I was gonna stay with her. (Stephanie)

Stephanie underwent surgery for removal of a small tumor, followed by chemotherapy and radiation. This small tumor was figuratively a bop on the head to say, "Hey, you need to change your life, so here is a little cancer."

Her surgery was "nothing" compared to the sickness caused by the chemical treatments. However, in spite of her sickness she got well enough to get her tenure and promotion to full professor as well as complete a major, multi-year educational grant. Nothing was going to keep Stephanie from her work and her students. In fact, she had a doctoral student graduating, and she wanted to be there to hood her but was concerned about her physical appearance, especially the loss of her hair; "How would my cap stay on?" She had just enough hair that it looked like she had hair, but what if a big wind came? Would her remaining hair and cap fly away as one? Fortunately, at graduation everything stayed in place.

Even though the chemotherapy was dreadful, there were some unexpected pleasurable effects. One of the things Stephanie discovered about her baldness was that her husband did not care if she was bald or not, nor did anyone else, it was all her. If she had to go through it all again, she would not think twice about going bald from the start. In fact, "walking bald" became a daily ritual. Each morning she would go outside, take her hat off to the world, and let the cool air soothe her head. For Stephanie, this was a wonderful, releasing feeling. Another pleasurable effect from her hair loss was that Stephanie realized that she really liked who was under her hair, that there really was a beautiful person inside, "I found out I really liked who I am under all the hair. I began to realize before it was over I really thought I was beautiful under there. I have a good head." In spite of what we see on television, in magazines and on billboards, our outer body does not have to be perfect for us to have an enjoyable life. Stephanie's story is an example of the gift of cancer.

Jennifer

Jennifer was 33 years old when she was diagnosed with colon cancer in 1983. She was 54 when we met for the first time at her campus office. Jennifer had taught English Education for ten years prior to her diagnosis and treatment and has continued to teach and work in this area for the past 20 years. She has two grown children who have their own homes; she and her husband, a sales executive, live in the city.

Growing up, Jennifer's sister did all of the household chores—cooking, cleaning, sewing, and so on—and Jennifer did not do any of those things because she was busy reading or doing things that her parents thought a princess should do. Her sister always said that Jennifer was the princess in the family, a perpetual student of the Princess School. It was not until after her cancer experience that she began to do things on her own such as hang pictures and paint walls. When people offered her help, she intentionally kept them at arm's length. Even though she was a graduate of the Princess School, she was a student of the Independence Institute.

She attends a Unity Church, which emphasizes the divine potential within every child of God. As she explained, it is through the teachings of Jesus that every person can realize and express his or her divine potential for a happier, fuller, and more successful life. Like others in this study, her faith and spiritual beliefs were tested and strengthened through her cancer experience.

It was by chance that Jennifer was talking to a friend of hers when she explained that she had an excessive amount of blood in her stool. She told her friend that she was thinking of going to see a doctor but, like the others, decided that it can wait for a bit. However, her friend was adamant that she needed to see someone right now as her own mother had just passed away from colon cancer. Jennifer went the next morning for an exam and by the time she arrived home, the phone was ringing. It was her doctor telling her that it looked suspicious and that she needed to come back to the hospital for more tests. Smiling she said, "Now you have to remember 20 years ago, they actually let you come to the hospital to have tests, not like it is now, there wasn't any inpatient, outpatient kind of thing." He also told her that she needed to prepare to check in. This idea of checking in was disconcerting, so she asked him what had he found, and he said that it could be a number of things, again saying that it was suspicious. As she hung up the phone, she thought *cancer*, since she and her friend had just discussed it a few days earlier.

The next day Jennifer checked into the hospital for what she thought would be just a few days but she ended up staying for six weeks. On the morning of her second day, with her mother in the room, a doctor came in, sat on the side of her bed, and told her that she needed surgery immediately. Jennifer became upset and started crying. Not only was she frightened about the surgery but also as a divorced mother with two small children, she wondered who was going to take care of them. Jennifer's first thoughts were about the welfare of her children, so she decided that she needed to have a will:

> I was thinking this was the death sentence and I just needed to do a Will, and somebody came up and notarized it and all that stuff in the hospital, right before my surgery. Really weird now that I look back on it. (Jennifer)

Jennifer had always played by the rules and now she had cancer. Life is not fair.

While in the hospital, Jennifer had two surgeries and then radiation. Her chemotherapy did not start until she was at her parents' home. While she was in the hospital, she did not want to see or talk with anybody, so she feigned sleep a lot, even when she was not sleepy. "I did not do anything because I figured I was gonna die." However, sometime near the end of her six weeks, a peace came over her, and she realized that she did not have complete control over every aspect of her life like she had thought, and so she let it go. This, Jennifer thought, was God's way of slinging more mud her way, one more lesson to show her that she did not have control of everything in her life:

> If I didn't learn anything else from this hospital experience, I felt that at the end of that, I really understood that all of this that you see is just the canning. This is not who we really are. I thought of myself as body and spirit and I know that is the case. . . . I am body and spirit, but I had made in my mind, it's like a 50/50 deal. I don't think it's that way at all, but I didn't know that upon entering the hospital. I felt like after that six-week period, I understood that better. That the body is just the case for the soul and that's what we really are, and once I got to be at peace with that whole and understood that better, I was on the road to recovery. (Jennifer)

Once Jennifer was able to make peace with her disease, recovery was a possibility. However, her real recovery did not begin until she started working again. Work allowed her to demonstrate to others, but more importantly to herself, that she would be okay. As Mathew Fox (1994) told us, "The only ones out of work are human beings. The very fact that our species has invented unemployment ought to give us pause. Unemployment is not natural to the universe; it contradicts cosmic laws. It is also not healthy" (p. 59). The basic purpose of work is to provide ourselves with the goods essential for our subsistence. Meaningful work that is pleasurable and fulfilling provides the basis for self-worth and a reason and purpose for living.

Valerie

Valerie was 60 years old when she was diagnosed with Stage IIIC ovarian cancer. She had taught science courses at both the graduate and undergraduate levels for over 25 years. Her husband, who passed away within six months of his lung cancer diagnosis in 1995, was a business teacher at the same university. She had one grown son who lived out of state, while she lived in the suburbs of Atlanta.

When we met, Valerie was five years post-diagnosis and treatment and was in excellent health. In fact, it was hard to believe that with her enthusiasm for life and her youthful appearance she was ever sick at all. My first impression of Valerie was of a person who loved people and loved life. Here was a woman who somehow was not only able to bounce back from several cancer surgeries as well as chemotherapy and radiation; she also surmounted the pain and agony of the loss of her husband, who was everything to her. Her love of life was evident in the way she spoke and the way she dressed. Her clothes were bright and cheerful, as if she was ready to go to the beach.

Her home was full of color, pastel walls, and glossy hardwood floors; and fresh cut flowers were abundant in her kitchen and family room. She was in the process of remodeling the back of her home by adding an enormous deck for entertaining. This deck was as big as half her house and had an open section with several sets of stairs leading to her backyard as well as a screened in area that could easily accommodate 30 people. This covered area had several ceiling fans, recessed lighting, tables, and chairs. Valerie smiled and her eyes twinkled as she spoke about her new addition that would become the ideal place for her survivor's group to meet. Even though it may appear to be your typical support group, she said, "We do not like to call it that. Our group, which is primarily women, is for survivors of all types, not just cancer victims; in fact, anyone who is in medical trouble can be part of our group." As we walked back in to her family room to sit down, I remarked about how wonderful a group like this can be, and without pausing to take a breath Valerie laughed as she said, "Yes, it is a wonderful club, but the initiation is hell."

As mentioned in the beginning, Valerie was diagnosed with Stage IIIC Ovarian cancer. Cancer is a progressive disease that goes through various stages and produces a variety of symptoms. According to Murphy et al. (1997), physicians use a classification system to describe the location of the cancer as well as the type of tissue involved. This classification system is called *staging* and is useful to describe how far a cancer has spread based on the size of the primary tumor and on whether and where it has spread (Murphy et al., 1997, p. 16). There are four cancer stages, represented as I through IV. A Stage I represents the early stage where the cancer is confined to an ovary or ovaries. Stage IV, the most serious, represents an advanced stage where the cancer has spread to other organs such as the liver or lungs. For Valerie, Stage III meant that the cancer had spread outside her pelvis and had spread to the lining of her abdomen and possibly to her lymph nodes.

Like others in this study, Valerie had an idea that something might have been wrong but dismissed it as a recurrence of ovarian cysts or an infected ovary, thus nothing to be concerned about immediately. Yes, she said, there were symptoms, but they were vague symptoms and that is the problem with ovarian cancer: It has vague symptoms. It was not until after her abdominal surgery that it was confirmed that she had ovarian cancer.

According to the American Cancer Society (2004) the lack of clearly identifiable symptoms has contributed to the relatively poor prognosis for women with ovarian cancer. Unlike other forms of cancer like breast and cervical, there is no good screening test for ovarian cancer.

> There was evidence that I had a mass in my abdomen and I think the doctor knew what it was, but I had surgery and then after the surgery . . . I thought it was an infected ovary, because that's what I chose to believe. But, in fact, it was not, so it was after surgery that I was informed about it. (Valerie)

Since her cancer was at an advanced stage, Valerie decided to participate in a clinical trial. The purpose of the clinical trial was to test the toxicity of taking the two standard drugs intravenously in the normal prescribed dosage along with a third drug which was taken by mouth. The clinical trial added an extra month overall to complete the six treatments because she had to wait for her white and red cell counts to return to their proper levels. Having cancer involves a lot of waiting. Waiting for doctors, waiting for treatments, and waiting for results. Who has time for all of this waiting? Valierie summed it this way: "I don't have time for this nonsense. Then you get cancer and you have a lot of time on your hands."

For some, having idle time seems like a waste, but having time to think and reflect about one's life is another one of those gifts from cancer. So many lives are spent in the fast lane, going at break-neck speed from one place to another. Busy people think it a tragedy if they have an unscheduled hour in their day planner. The end result is that we have transformed ourselves from human beings to humans doing. Cancer survivors understand the special gift of time.

Samantha

Samantha, like others in this study, was a higher education professional but with one major difference: She did not have cancer; her younger sister Sonya died from the disease. Samantha was included in this study because she brought a unique perspective of the effects of cancer on the lives of higher education professionals. Samantha was an experienced teacher with over 25 years in the area of Special Education. She is married and has a teenage son. She and her family live in the south part of the city. Her religious affiliation is Methodist, and her belief in God and God's plan is resolute.

Samantha's sister Sonya (10 years Samantha's junior) was diagnosed with breast cancer in 1999 and died in 2001 at the age of 41. Sonya was married and had a daughter the same age as Samantha's son. When I received Samantha's e-mail, "Dear Hank, If you want to talk to someone whose life has been turned upside down by cancer, I am your person," I knew she had a lot to offer.

The Chinese symbol or pictograph for the word *crisis* is a composite of two other pictographs: the symbol for *danger* and the symbol for *opportunity*. For thousands of years, the Chinese have known that a crisis can be a dangerous time but also a time to look for new opportunities. Life can be even better and more fulfilling if we can find ways to endure hardships together. For a cancer victim, the dangers of treatment are both real and imagined. One of the dangers becomes "How do I share the diagnosis without creating chaos and turmoil?" A common question is, "Should I tell my family?" Despite the emotional pain, despite all the difficulties of treatment, the best course of action is to share with your family what is happening to you. People who are truly close to you, even though you may not say a word, will notice that something is not quite right. Of course, if you have any relatives who are emotionally or physically unstable, it may be best to have a neutral person, such as a social worker, help you make this decision.

When a person shares his or her diagnosis with family members, every new and old pain comes under scrutiny. They immediately think that since you have cancer, maybe they will get it too. In addition, well-meaning caregivers may begin to neglect their own well-being. In Samantha's situation, she and her sister were already close, and Sonya's illness and rapid decline brought them even closer. However, the crisis of cancer, the danger, and opportunity had its price. While it brought them even closer, Samantha's health and professional life entered into a downward spiral.

One afternoon as Sonya was applying suntan lotion, she felt a small lump in her breast. Her initial reaction was that it could be anything. She told Samantha about it and they decided that she should have it checked out. The x-rays and subsequent examination confirmed that she had cancer. The good news was that it was localized and that with chemotherapy, everything would be fine. Samantha and Sonya were thankful, as they believed they had dodged the bullet. However, after a few months, Sonya was having problems breathing so Samantha went with Sonya to the doctor for additional x-rays. There was evidence of fluid on her lungs, which required immediate treatment.

When Samantha was in the waiting area, a young female technician came up to her, placed her arms around Samantha and said in a weeping voice, "I'm so, so sorry. I saw my mother and aunt go that way." Samantha said to herself, "What is she talking about? How could this be? This young technician is not a doctor, she does not know, this just can not be true." However, Samantha did know, and said to herself, "I knew in my heart of hearts. . . , " and so when Samantha saw her sister later that morning she had to pretend that she did not know that her sister's cancer had metastasized and her condition was terminal. Unfortunately, the time never came for Samantha to tell Sonya that she knew the end was near. Even to this day, Samantha does not understand why Sonya's doctor never told her that she was terminal, even though Samantha knew she was:

> I think it came as a real shock to her, because when the chemo failed the second time, she did say well that's a surprise. She's a real stoic, you know. She never said a whole lot anyway, but the things she did say, I wasn't expecting that or, you know, that sort of thing led me to believe that he really never told her and so I never felt . . . I didn't want to say look, your time . . . I didn't want to say that kind a thing to her, so . . . and now I wonder if I should have, earlier . . . if I should've mentioned to her, 'cause I think she probably would've quit work. She worked up until the week before she died. I think she probably would've taken some more time just to . . . I don't know what . . . be with her family and more. [sniffling] I kind a felt like they robbed her of choices and I know that, you know, this robs you of a lot of choices, but I think that the doctors, in trying to spare her, really did her a disservice, so um, I carried that knowledge all through and it was hard to . . . you know, to go to work and to care . . . about teaching. (Samantha)

Even today, Samantha carries the guilt of not sharing her secret with her terminally ill sister. Moreover, she does not fully understand why she did not tell Sonya something so important. Cancer has this rippling effect of touching not just the life of the person who is ill but also the people who surround that person. Thus, these rippling effects can create personal and professional demands that are difficult to manage. In turn, these demands have the ability to create negative emotions and actions, which can cause stressful situations. These stressful situations create the proper environment in which cancer can flourish.

All of the participants in the study used their life experiences to interpret the experiences of realizing they had cancer and then moving forward from that point. The question is, "How do people move forward if they do not know which direction they are facing?" Each participant chose a direction and then traveled that path. I could not help but learn new and fascinating information from each one of them. Their stories about their diagnosis and initial reaction provide the base for moving into a discussion of the three emerging themes. These themes are not in any hierarchical format but rather in the sequence that participants tended to share their survival experiences. No one theme has more or less importance than any other theme.

A time for pause is in order. Unlike a computer's memory, our memory is not a read-only memory. Each time we recall an experience, we reflect on that experience, and then we write it back to our brain in a slightly modified version. No matter how I might have felt at the time about an experience, every time I recall that experience, my memory of that experience changes. Thus, I have interpreted in my own way what the participants had to say along with what I have experienced. Another researcher may view the participants' words in a completely different way and thus come up with different interpretations, results, and findings.

Research Question 1

What is the essence of the experience of cancer for a higher education teacher?

In this section, the discussion focuses on metaphorical descriptions of cancer, thoughts as to basis for the disease, and possible causes.

Sub Theme – Cancer as a Metaphor

One of the ways in which we are able to share our thoughts is through stories. These stories can be about us or about others and frequently involve the use of metaphors and other figures of speech. The word *metaphor* comes from the Greek word *metapherein* meaning "to transfer" (Hermans, 2003, p. 91). In its simplest meaning, a metaphor is an implicit comparison between two distinct entities. Thus, the combination of the two creates something new that does not already exist. A metaphor can help us understand and experience one kind of thing in terms of another and is defined as "the application of a word or phrase to an object or concept it does not literally denote, in order to suggest comparison with another object or concept" (*Random House College Dictionary*, 1988, p. 840). Two examples of metaphors are "A mighty fortress is our God" and "A ship plowed through the sea." In the first example, God is portrayed as a strong and sturdy structure able to withstand the tests of time. In the second example, the image is of a ship making its way, deliberate and steady, like a farmer's plow making its way through the fields. Metaphors such as these bring a concept or an object of discussion to life.

Cancer is frightening for any human being. Even the astrological sign for cancer is scary – the crab with its sharp claws, pincers, and potential for pain. When people talk about cancer, war is often the metaphor of choice. Since the causes of cancer and its many variations continue to be unknown, the battle metaphor continues. There seems to be a strong tradition to do battle against cancer utilizing the technology of surgery, chemotherapy, and radiation. Thus, survivors of cancer wear the badge of a cancer conqueror and share a unique fellowship of pain. According to Cousins (1979), those outside this fellowship "have great difficulty in comprehending what lies behind the pain" (p. 153). This idea of war against cancer became law on December 23, 1971 when President Nixon signed into law the National Cancer Act. This act initiated a national assault on cancer, and Congress designated this act as a national crusade to be accomplished by 1976 (Moss, 1996). Cancer survivors wage a war against the disease as if a foreign army has invaded sacred territory. In this case, the foreign army is the cancer and the territory is the body, mind, and spirit.

Since there are so many variations and types of cancer, I wondered what metaphors could be used to describe cancer. Each participant was to think of an animal or an insect that would metaphorically represent his or her cancer. I was also curious to learn if there was a correlation between the size of the animal or insect described and the size of the person's tumor or the duration of the person's treatment. All of the responses were similar in that the metaphor was indeed the way they saw their cancer. It was a destructive thing, and removal was necessary. However, there was not any correlation with the metaphor and the size of the tumor or the length of treatment.

When asked, Bill immediately thought of two creatures: the cicada and an aquarium snail. The cicada is a flying insect related to the harvest fly. These insects appear every 13 to 17 years to mate, lay their eggs, and then die within 40 days. One distinguishing feature of these insects is the male's megaphone-like chirp, which one can hear from a distance of a half mile. In fact, these males make the loudest sound in the insect world. When the cicadas come out, it is difficult not to notice them. As Bill explained, "It was there, it sung loudly, was very short lived in my life." Like the cicada, Bill's cancer was underground for some time but then, once discovered, he promptly and deliberately put a plan together to deal with it.

The second creature, the aquarium snail, was something that Bill had thought about for some time. As harmless as these creatures appear to be, they rapidly reproduce and can over-populate a tank in a matter of weeks. Snails are good aquarium janitors because they eat any leftovers in the tank. When you look at the feeding strategy of the snail, it is not systematic or sequential, and it is not intentional to anyone except perhaps the snail itself. As the snail zig-zags its way across the glass, we zig-zag our way across the surface of the earth, learning new life lessons along the way. Even though these lessons may not be welcome, as in learning how to deal with cancer, Bill believes that each lesson learned during the zigs and zags has the potential to make us more whole, and life, as he now sees it, is a journey into wholeness:

> I had to have cancer to become more whole. Any experience that I have had in my zigging and zagging through life . . . whatever I needed to work through . . . cancer has helped me do. I do highly accept and embrace the notion that in every this . . . whatever those this's are . . . is the opportunity for me to become more whole. (Bill)

When I asked Eddie if he could think of an animal or insect that would describe cancer, he thought for several minutes and instead of coming up with a metaphor, he talked about his background in biology and his love for zoology. In essence, he does not view insects or animals in a negative light. In fact, since he is pro-animal, all of the creatures on earth serve a purpose and are an integral part of the earth's ecosystem. The only animal that he could remotely associate with cancer was the ancient story about the Arab and his camel.

Once upon a time, an Arab wanted to cross a wide desert. He fed and watered his camel well, and got all the necessary supplies, and started out. The very first afternoon, a sandstorm began to blow. The Arab got off his camel, pitched his tent, and climbed in to wait out the storm. After a while, the camel said, "Master, pray let me put my nose under your tent, for the sand is blowing in my nose. If I suffocate, I cannot carry you across the desert." The Arab, being a compassionate man, let the camel put his nose under the tent.

Shortly thereafter, the camel said, "Pray, Master, let me put my eyes under your tent, because the sand is blowing in my eyes, and if I go blind, I cannot carry you across the desert." The Arab thought about this and realized that a healthy animal was important if he wanted to get to his destination safely. So the Arab let the camel put his eyes under the tent. A short time later, the camel asked, “Pray, let me put my ears under your tent, as the sand is blowing in my ears.” Within a few minutes the Arab heard, “The sand is blowing on my cut shoulder. Pray, let me put my shoulders under your tent.” The polite requests kept coming until finally the camel was completely inside the tent. However, the tent was too small for the Arab and his camel and so the camel said, “The tent is just large enough for me alone. Please get outside, Master.” The camel then pushed the Arab outside.

One interpretation of this story is that a camel is anybody or anything that can take control of your life if you let them (the old saying . . . give an inch, take a mile). As Eddie was sharing this story, I was thinking that he was the Arab and the camel was his cancer. I was wrong. The Arab was his cancer, and he was the camel. As he saw it, he wiggled and fought his way into the tent until there was no room for both. The cancer had to go. By being completely inside the tent meant that he was free and clear of his cancer, in other words, cured. Eddie concluded his story by adding that he has had enough experience with and knowledge about cancer to know that it could reappear at any time. Nevertheless, for now, “I hope it doesn’t turn out that it’s the other way around, that cancer is not the camel.”

Some of the other animals discussed included a snake and a hyena. Erin thought that an appropriate metaphor for cancer is a snake, especially the boa constrictor. The boa quietly snakes its way around until it has its prey within reach. With one mighty lunge, it sinks its fangs into its prey. Erin remarked, “Like cancer, it doesn’t make a sound.” Boa constrictors are carnivores and mainly hunt at night using their heat sensors. Once it catches its victim, the snake wraps its body around the prey in coils. The boa does not squeeze the life out if its victims but rather each time the prey breathes in, the coils tighten. With each inhale, the coils become tighter and tighter until the victim is no longer able to breathe. With no more breaths left, the victim dies. Like other snakes, the boa swallows its prey headfirst by unlocking its jaws. In fact, the boa can swallow prey larger and wider than its own mouth. The boa, like cancer, is doing what it knows how to do. Erin summarized,

> The snake is not bad. I mean we made it bad by the scripture's [laughs] point of view, but [laughs] by its nature, it's not a bad creature, it is only eating because that's what's in its nature to do. (Erin)

Like the snake, cancer is doing what it is trained to do, namely, to divide rapidly and out number the good cells. Unlike the snake, cancer is bad. However, we create the setting within our own bodies for it to find a home. In order for a snake or a disease to exist, it must have the proper environment.

> I could have said, oh, you can stay if you want or [laughs] . . . that it doesn't matter to me . . . yeah, it did matter to me. So you take up residence someplace else, but not here. (Erin)

For Erin, like the Arab and camel story, there was not enough room for her and her disease. She had to tell her intruder that their presence was an unwelcome presence and that it had to go.

Stephanie described her cancer as a leech.

> It's something burrowing and digging in and attaching itself. And that would be what I'd think of sucking you or sucking blood or sucking stuff out of you and then surviving on that. Um, something inside you don't want inside. Don't know how it got there, but it got there. Not pretty, black, yucky, (laughs), invasive . . . uh, all those things, you know. (Stephanie)

Samantha said that cancer was like the hyena. The word hyena comes from the Greek word *hus* which means "swine" or "pig." However, the hyena is not related to the pig or dog but is in a family all its own. The hyena is unique in the animal kingdom by the way it survives. Hyenas live alone or in pairs and when hunting, they follow other animals. A common perception of the spotted (also known as the laughing) hyena is its feeding pattern. Even though they are capable of tracking down their own prey, they usually feed on the remains of animals killed by other predators. Hyenas take the path of least resistance; they prefer to scavenge or attack an animal that is already in trouble. Cancer works essentially the same way. The destructive cancer cells start to consume a person who is already down, both physically and mentally.

Samantha described cancer as an evil, aggressive animal, sitting there, lurking, hiding in the shadows, and waiting for an animal to be brought to its knees. Once the animal is vulnerable, the hyena attacks, laughing as it destroys. Samantha said, "What do hyenas do? Cows produce milk. Birds are lovely to watch and make wonderful sounds. Dogs and cats make wonderful pets."

> I see cancer going ha ha ha ha ha . . . you know, laughing at you and it's just this . . . this evil thing. (Samantha)

The hyena and cancer have one main thing in common: They both attack when the prey is most susceptible and vulnerable for attack.

Sub Theme – Predisposition and Anticipation

Anyone can get cancer. Cancer does not just happen on its own. It is usually the result of one or more factors. We cannot prepare for cancer no matter how hard we try. The disease comes along and disrupts every aspect of one's life. Cancer, according to Lindblom and Nordenskjold (1999), is a "genetic disease in the sense that the malignant growth pattern is a result of a genetic alteration that can be transferred from one cancer cell to its daughter cells" (p. 439). Lindblom and Nordenskjold estimated that between 5 and 10 percent of tumor-based cancers (such as breast and colon) are due to family history. This means that an inherited faulty gene predisposes a person to a higher risk of particular cancers. The remaining cancers are not hereditary but result from damage to genes throughout one's lifetime.

While several participants were able to associate their illness to genetics, others were able to point to factors besides family history. Contributing factors include, but are not limited to, gender, upbringing, culture, and life-style influences. These factors may influence not only how long a person may live, but also what illnesses one may get, availability of treatment options, and the ways in which one responds to the threat of an illness. In addition, contributing factors include exposure to a toxic environment and working in a hazardous or stressful occupation; even specific traumatic life events may speed up the occurrence of an illness. Norman Cousins (1979) wrote that "cancer, in particular, has been connected to intensive states of grief or anger or fear" (p. 86). In addition, Hans Selye (1976) told us that the most serious health problem of our time is stress. Dr. Selye described stress "as the emotional or physical wear and tear in the human body, which is beyond the capability of any individual" (p. 472).

Schwartz (2004) said that in 2003 there were more than 170,000 new diagnoses of lung cancer and over 150,000 deaths from lung cancer in the United States (p. 86S). According to Schwartz, 80 to 90% of lung cancer incidence is attributable to cigarette smoking, while only 10 to 15% of all smokers develop lung cancer. In addition, 10 to

15% of all lung cancers occur among nonsmokers. These statistics suggest that susceptibility to cancer may be significantly correlated to genetic predisposition.

In Lewis Carroll's *Alice's Adventures in Wonderland* (1992), the Mad Hatter received his name based on his "odd behavior." The hatter was not actually mad, but his love for hat making and his prolonged exposure to the toxic chemical mercury caused him to have mercury poisoning. Mercury was a common chemical used during the process of converting animal fur to felt. Since the hatters' workrooms were usually lacking adequate ventilation, the toxic fumes were absorbed into their bodies. This continued exposure to mercury soon caused mercury poisoning, which in turn caused symptoms of trembling hands, lack of coordination, slurred speech, memory loss, irritability, and anxiety. During that time there was limited, if any, knowledge about the chemical mercury and its effect on workers. The phrase *mad hatter syndrome* is still in current use. Even today, with our vast knowledge about mercury and its negative effects, mercury poisoning still occurs because some dentists still use silver fillings.

Millions of people still lay out in the sun, even though it has been widely suggested by the medical community that skin cancer is highly correlated with doing so. It becomes evident that our society and its practices produce environments and situations that can literally cause a person to become ill. Thus, it seems that whether we are healthy or sick depends not only on genetics but on social pressures and circumstances as well.

As will be illustrated, some participants attributed their cancer to genetics, citing that other members of their families had had cancer. Some even described losing a loved one to the disease. Several participants commented on their anticipation of things to come, that is, getting a cancer diagnosis and treatment and what else was going to happen. Some even indicated that they had envisioned themselves with cancer prior to the actual diagnosis. A few participants mentioned that they were not surprised with a cancer diagnosis since several of their family members had had cancer. Only those participants who indicated that cancer ran in their families mentioned anticipating or envisioning themselves with cancer.

For Bill, getting prostate cancer was not a total surprise. He believed that there might be a combination of many things, including an inherited gene that causes cancer. His grandfather died of prostate cancer, and there is a history of cancer in his family. In conjunction with the family history, there is the intersection of other factors such as exposure to chemicals, a less than healthy diet than is desirable, the use of alcohol or drugs, and stress. All of these may be triggers for genetic dispositions.

> I think probably if I had to say okay, what caused my cancer, I'd have to say that it was genetic in that I had the predisposition for it and probably my biological and psychological inability to handle a lot of stress helped that to make manifest that already there was a predisposition for cancer. I had a lot of stressors prior to my cancer emerging. A decade of heart problems, losing a mother and father, making a transition to a new job, quitting a job of 17 years, leaving family and friends behind, and venturing out with a companion whom I've been with now for 12 years. (Bill)

Both Mary and Stephanie had a family history of breast cancer. Mary's mother had numerous surgeries for removal of lumps in her breasts, and her father died as a result of prostate cancer. Mary believed that we all have cancer and that we all will get it at some point in our lives. It is simply a matter of the cells getting out of hand and our immune system being incapable of fighting the disease. Even though Mary had a small tumor that was barely noticeable, in her words, "it never really showed up but it was there for a long time." It was not until the sudden and tragic loss of her husband that Mary's cancer journey began:

> With the loss of my husband and everything else that was going on at that time, my immune system . . . I thought I was doing great, 'cause I kept taking my vitamins and I didn't get a cold, but my immune system was mightily hampered or impaired. (Mary)

Another aspect of cancer anticipation that emerged from the participants who attributed their cancer to genetics, either partly or completely, was that they had a clear sense of treatment and of the subsequent life changes that would result. These imagined drastic effects would occur prior to any treatment. They reflected on experiences with parents, spouses, and siblings who had had cancer.

> Well my mother had breast cancer in 1967 and is going strong at 80. I've always known that I was potentially a likely candidate for breast cancer. Then her sister, when she was 80, had breast cancer, too. So both the maternal aunt and a mother and I've always kind of known or not known. I mean I was never fatalistic about it, but thought I wouldn't be surprised if I ever heard it. And then I got my diagnosis in 2000. (Stephanie)

Even though Stephanie was concerned about her cancer treatment and outcome, what she feared most was that she would be afflicted with lymphedema, just like her mother. Lymphedema is a swelling of the legs or arms and is a serious problem for many breast cancer survivors. It may occur during treatment or several years later. Deo (2004) wrote, "Except for the breast cancer recurrence, no event is more dreaded than the development of lymphedema" (p. 10). Lymphedema results from an imbalance in capillary function and lymph drainage, which results in a buildup of fluid and protein in the affected limbs. In addition, lymphedema, according to Rymal, (2003) compromises quality of life through pain and pressure as well as altering one's self-image (p. 449). The causes for lymphedema include surgery, radiation, infection, and genetic disposition.

Since each diagnosis of breast cancer is unique, there is no one standard treatment. However, there are three broad types of treatment: (a) local or regional treatment which is aimed directly to the breast and surrounding areas; (b) systemic treatment, which aims at treating the whole body or system; and (c) alternative and holistic therapies that are used to treat the whole person, including the mind, body, and spirit (*Overview of Options*, 2004). In treating breast cancer as well as other cancers, there is a concern regarding the disturbance, treatment, and possible removal of lymph nodes. Since these nodes are sensitive to radiation, an impaired immune system is often the result. This is why many cancer survivors are concerned about the disturbance and removal of their lymph nodes and the possibility of lymphedema.

There is an expectation for cancer survivors to get back to normal as quickly as possible; however, since there are no immediate cures for lymphedema, it continues to be a significant long-term problem. In our society, there is constant pressure to look good, and lymphedema has a negative impact on a woman's appearance, thereby affecting her self-esteem as well as her social interactions. According to Ridner (2002), "Women with lymphedema view it as a constant reminder of cancer" (p. 1286).

> My mom suffers from severe lymphedema. My mom is probably 5'2" and her right arm now, from her mastectomy, is a huge mammoth . . . and she has lost everything in the shoulder. She had nothing but a bone holding it on there and she has now lost all use of it, except to push things against. I thought, hmm, the lymphedema is a major part of what scared me. (Stephanie)

For some, becoming a person with cancer can be quite different from what you envision. Eddie thought that once his doctor told him "You have cancer," his world as he knew it was forever changed. It seems as though there is never a minute's rest, your mind is always thinking about cancer, what will and will not be.

About one year before Eddie's cancer diagnosis, his mother sent him a newspaper clipping about a man who had overcome esophageal cancer. This story was unusual because the man was much younger than the typical esophageal patient. He did not smoke, and he did not have any of the risk factors for esophageal cancer. He had gone to several doctors who told him that there was nothing that could be done for him. The young man persevered and finally found a doctor who was trying a revolutionary procedure of shortening the esophagus, pulling the stomach up, and then reattaching it all. The young man had the procedure, and as far Eddie knows, the young man is fine today.

When Eddie was in the chemotherapy ward for the first time, he remembered this young man and thought about how hard it must have been to go to these doctors and have them say, "There is nothing we can do for you." Once Eddie returned home, he wrote this young man a long letter but never mailed it. "I have it on my word processor today and I never mailed it. I don't know why."

Did Eddie fear that the letter might come back marked "deceased"? What if the young man did write back and talked about how everything was fine initially, but now he had a recurrence? Fear is a normal reaction to cancer but you cannot allow this feeling to control your life. It is natural to fear something that threatens you, especially when it concerns your future. However, it is not natural for your fear to dominate your other emotions, and questions such as "Will I be able to cope?" and "Will I die?" are unproductive. It seems that fear and anticipation often tend to be far worse than the actual experience. People with cancer have an increased apprehension about life. It is not that people treat us differently, but we feel differently about ourselves. Our bodies change, our minds change, our very existence changes, and how we view the world is forever changed. As Murphy (1987) said, "There's no cure for life" (p. 221).

Sub Theme – Reflections of Causes

The diagnosis of a life-threatening illness is an extraordinary stressful event. Often one's initial response is one of shock. Once the shock has subsided, there begins an intensified awareness of one's own mortality. Thinking about death causes an individual and family members to look back on previous experiences for possible causes as well as to perform a reality check of where they are now. For many, discovering or uncovering the root of the illness may help them to understand their illness. Understanding the disease helps with coping and survival strategies as well as proposed treatment and care.

One of the ways in which individuals regain control of their situation is to investigate the possible causes that attributed to their illness. Attribution theory suggests that when an individual experiences a significant change in life, he or she will initiate a search for the underlying causes for the change. According to Proudfoot and Shaver (1976), "Attribution theory is attractive . . . because it deals directly with a person's interpretation of his own experience" (p. 322).

When Ronald found out about his thyroid cancer, he immediately started to do research via the Internet to find out more about his type of cancer and its possible causes. His first stop along the information superhighway was The National Institutes of Health (NIH) Web sites. He found a study conducted by the Centers for Disease Control (CDC) about an atomic energy plant that was near his hometown. Since he grew up near this facility, he wondered if there could be a connection between the two. While he found the research interesting, it was inconclusive, and once he was through with his treatment, he lost interest in any more research.

However, Ronald said he will never know whether growing up downwind from the reactor influenced his getting cancer. There are theoretical reasons to believe that his cancer was related to the reactor's proximity, but he did not have great confidence in the actual research because of the artificial boundaries selected by the researchers. The researchers in this study handpicked the specific county to study and left out Ronald's county.

Besides the possible exposure to the reactor, Ronald also had an unfortunate involuntary shift of job activities. Could this additional stress have triggered the cancer that was dormant in his body? Ronald remarked that it may have exacerbated it some, and there may have been some perturbations in his life related to having had cancer, but nothing of any serious note:

> I was just as exposed as people in that county but I was excluded. I mean it is somewhat arbitrary. On the other hand, I do not have evidence on an individual case to argue against the research either. (Ronald)

When Erin reflected on the causes of her cancer, she could not help but say that the emotional and psychological stress of her job as an associate pastor at a church plus her father's illness created a proper environment for her cancer. It seems that many people may jeopardize their health to maintain relationships.

> I was at a church for two years and the last six months, well the last year was when my dad's illness became terminal and he died six months before I left. I was miserable in this church. I did not feel like I was a fit. I learned that about myself and so those four years, which would have been three to five years before the diagnosis, were really years of uncertainty and turmoil within me. (Erin)

In addition to genetic, occupational, and environmental factors as possible causes for cancer, can one's personality also be a contributing factor? In other words, is there a "cancer personality"? Brodie (2004), a physician for the past 28 years observed that his cancer patients seemed to exhibit certain characteristics such as a strong desire to care for other peoples' burdens, a need to take on extra obligations, a history of suppressing toxic emotions, and a lack of ability to cope adequately with stress. He has found that it usually takes at least two years for cancer to appear after experiencing a major event such as a loss of a loved one or loss of one's job. For several in this study, the loss of a loved one or job change was the mitigating factor. However, other points of view exist regarding common factors in cancer patients' personalities.

Is it unreasonable to think that one type of person is more likely to get cancer than another type of person? Perhaps it is unreasonable to think this way since all types of people get cancer. Whether one is calm or excitable, educated or non-educated, religious or non-religious, all can get cancer. Even newborn babies can get cancer. When one reviews history for the explanation of a certain disease, often times the cause points to a specific type of personality. For example, Harpham (2003, p. 186) said that before scientific medicine, tuberculosis was thought to come from a "tuberculosis personality." Now we know that a tiny organism causes tuberculosis.

A common thread for many of the participants was their cancer-susceptible personality coupled with one or more traumatic events. Personality in this context is "a combination of long-lasting and distinctive behaviors, thoughts, motives, and emotions that typify how we react and adapt to other people and situations" (Plotnik, 1999, p. 433). Thus, thinking and acting a certain way may create the ideal environment for cancer to interrupt one's life.

> I think it happened to me and I think my own personality made it as bad as it was. My personality of not wanting to go to a doctor, not wanting to bother, not wanting to have the ovaries taken out. I just didn't want to deal with them. They make me crazy. Be seated please . . . be seated, the doctor is in, and you wait

> hours to see the doctor. I don't like to have my car serviced, because I don't like to wait. I don't like to do anything that makes me feel like I'm in prison. I think it was my own personality of being just so focused on I have to go to work, I have to go to work, I have to go to work [laughs]. (Valerie)

For Valerie, the loss of her husband two years earlier and her behaviors of not doing anything once she had the signs that something was wrong contributed to her situation. I believe that Valerie's need for control over her life was a contributing factor to her delayed diagnosis and treatment. Based on her behaviors, as well as the behaviors of others in this study, it is evident that people like to be in control and seldom like to relinquish that control to total strangers.

Research Question 2

How has cancer affected higher education teachers' professional lives?

Theme 2 – Dealing with Cancer

In this section, the discussion will focus on how the participants dealt with the disease with regard to utilizing coping strategies, self-talk, and rituals.

Sub Theme – Coping Strategies

Three of the most feared words in the English language are "You have cancer." The media and the public have long used the words *cancer* and *death* as if they were synonyms. Therefore, hearing those three words is a traumatic experience. Receiving a diagnosis of cancer becomes an emotional roller coaster not only for the person diagnosed but also for friends, family, and others. Whether you are in the examining room or at home when you get the news, for a moment it seems as though your breath is gone. Immediately all of the oxygen is gone from the room. It is at this point that you are in the worst of times for two reasons: (1) you have cancer, and (2) you do not have a plan. A plan to deal with cancer is critical because cancer does not wait. Several of the participants remember the details of that day.

> I remember the day specifically. My husband and I were there when the results came back. It was my 51st birthday [laughing] and the doctor walked in and said it is malignant. So, we just kinda looked at each other and, it was that shock of, my life's over . . . I'm dead . . . all of that. It was February 15th and yet, together, we got real agitated enough to feel we needed to be more in control. I just felt really out of control. That thing had terrified me. (Stephanie)

Cancer affects everyone within the cancer victim's sphere, not just the person diagnosed. As Arthur Frank (2002) wrote, "Critical illness leaves no aspect of life untouched" (p. 6). The illness has the power to change the person as well as the family, physically, mentally, and spiritually.

How one reacts to these changes of stress and uneasiness is a reflection of learned coping styles. The word *coping* refers to the "process whereby one attempts to manage situations that place intense demands upon one's resources and anxieties" (Doka, 1993, p. 41). A cancer diagnosis imposes demands that for many seem impossible to meet. To respond to these demands, one utilizes coping strategies. These strategies include having a spiritual belief, a positive mind-set, social and personal support, information gathering, and humor. By using various coping strategies, one attempts to return to a normal way of life as quickly as possible. Those who live through the cancer experience realize that the first few months is a time of change. It is not so much getting back to their original way of life; rather, they experience a "new normal," which is similar to but not exactly like their life prior to diagnosis and treatment. This new normal may include changes in diet, physical activities, and social interactions. Life after cancer is never the same.

Coping as described by Murphy et al. (1997) is a way to learn how to maintain "the highest quality of life with a chronic illness" (p. 383). The term *Quality of Life*

(QoL) examines how an individual enjoys his or her life. Quality of Life is a complex, multi-faceted term that encompasses physical, psychological, and social aspects of an illness and its treatment. Quality of Life looks at the numerous factors that contribute to the goodness of life as well as ones' happiness. Physical factors that can negatively affect the goodness of life include fatigue, tiredness, sickness, nausea, pain, and changes in appearance. For many cancer survivors it is a change in appearance that becomes the outward sign that one is ill. A common change of appearance is hair loss due to chemotherapy. Losing one's hair is a daily reminder that one has cancer. The devastation of losing hair to chemotherapy is upsetting, especially for women. Our society places a huge premium on looking good. Advertisements for hair care products are everywhere, from grocery store aisles to highway billboards. Chemotherapy for both men and women would be easier if it were not for the hair loss. One can hide scars from surgery and a port for the infusions, but it is difficult to hide a balding head. However, for some, hair loss is a positive thing; it seems to them to be proof that chemotherapy is working. Unfortunately, not everyone is as positive about hair loss, as an attractive outward appearance seems to dominate our society.

Psychological factors include worry and depression, denial, and uncertainty about the future. A constant concern for cancer survivors is that of a recurrence. How does one know if he/she is truly cured? People diagnosed with cancer often look to survival rate statistics to see where their illness fits in compared to the others. Even though the data show that there is a chance for survival, death is a possibility as well. Finally, social factors that can positively affect the goodness of one's life include a sense of community and belonging; relationships with co-workers, family, and friends; and the ability to reach out and share with others. Being able to share what you are going through can have a positive impact on recovery. How successful or unsuccessful an individual is at dealing with these factors has an important and tremendous impact on how a disease is treated and managed.

In order to cope effectively, one must be actively involved in the management of one's life. All of the participants in this study were actively involved in dealing with their disease. Active involvement includes gathering information, selecting medical staff, selecting medical treatment, and follow-up. Those individuals that have a belief that one can influence one's own thoughts and behavior, also known as self-efficacy, are better equipped to cope with their disease. Research shows that those who are active and effective participants in their disease have positive emotional outcomes. Dr. Bernie Siegel found that he could predict which of his cancer patients would go into remission by asking, "Do you want to live to be one hundred?" Those that answered with a "yes" were the ones that were most likely to survive (Warren, 2002, p. 31).

Even though cancer is a horrible disease, it does create opportunities for people to become closer, to provide for deeper and more satisfying relationships, and to show how precious life is. You and your loved ones will have numerous challenges, and no two individuals deal with cancer in exactly the same way. In response to their illness, many take a step back and examine not only who they are but also what is important both personally and professionally. This self-imposed new look at life is what many cancer survivors call the *gift of cancer*. In terms of coping, those who accept this gift seem to adjust better to the roller coaster ride of cancer and its treatment. As Nietzsche said, "Was mich nicht umbringt, macht mich stärker" (That which does not kill me, makes me stronger) (Frankl, 1984, p. 103).

The way people respond to a life-threatening illness is often dependent upon their coping style. Imagine for a moment that your doctor tells you have cancer and that there is a chance, real or perceived, that you could die. Even though the words "You have cancer" seem to be more commonplace now than ever before, you and I never expected to hear such distressing words. However, now that you have, you have to think about what you will do. For most cancer victims, immediate thoughts are on surviving: making it through today and on to tomorrow. You have to do whatever is necessary to stay alive regardless of the diagnosis and prognosis. Once you have established your survival plan, the best survivors are the ones who take an adverse situation, gain strength from that situation, and begin to thrive on it.

Siebert (1996) wrote that people who thrive after experiencing a disruptive event go through five distinct stages. The stages are (1) getting an emotional balance, (2) utilizing coping strategies, (3) adapting a new reality, (4) recovering to a stable condition, and (5) learning to be better and stronger than before (p. 91). All of the participants discussed these stages, but they did not follow or include all of the stages as described by Kübler-Ross (1969) in *On Death and Dying*. Kübler-Ross was influential in the area of patients' rights to information and informed consent for treatment. While Dr. Kübler-Ross listed these stages as denial and isolation, anger, bargaining, depression, and acceptance, the only ones discussed by the participants in any detail were denial and anger. Even though Jennifer and Eddie thought at first that cancer was a death sentence, once they reflected on their illness and developed a plan, they soon came to realize that with proper treatment and support survival was certainly possible.

Denial is a useful coping strategy that allows for analysis and decision-making on small pieces of information. To avoid being overwhelmed with information and decisions, one can choose to deal with manageable pieces. This piecemeal approach allows for gradual acceptance of the disease as well as time to develop a plan. In addition, denial becomes a limited form of protection that will eventually fade away. When a person receives a cancer diagnosis, the only thing that person sees is cancer. It is as though it is right in front of his/her face, blocking the view from anything else. Imagine a racehorse with a cancer diagnosis; the horse would be wearing blinders, limiting the view. When an individual gets the diagnosis, imagine one's hands placed in front of the face, fingers intertwined. The only view one gets is through the small spaces between the fingers. Fortunately, for many cancer victims, time can be a friend. Over time, the fingers start to separate, and the hands start to move slowly along the sides of the face, moving away from the eyes, along the temples, over the tops of the ears and finally resting at the back of the head. The cancer is no longer front and center, blinding the view. The cancer diagnosis and the whole cancer experience is not gone but has faded to the background. This ability to see allows for thinking and planning, which is essential for cancer survival.

When Erin first realized she had a lump, she went to see her regular doctor who told her that it was probably a bruise to her rib cage. Since she was due for her mammogram, she also decided to have an ultrasound. Erin remembers telling the technician that soreness "is right here" but the technician replied with "nothing there." Erin talked with her doctor the next day and again was told, "it is nothing." Erin was not completely at ease with the results but said to herself, “So, I’m okay. I’ve known her for a while and I trust her.” Erin’s initial use of denial allowed her to function in a world of uncertainties and unknowns. However, she did not stay in this state of denial for long.

Mary, like others in this study, initially denied that anything was wrong. Yes, the tumor seemed suspicious and a more thorough examination would have been appropriate, but for now she said, “I don’t have time for this.” Likewise, Ronald was actually annoyed with himself that he did not do anything immediately even though for several months he had difficulty swallowing. As he put it, he just did not pay any attention to his body because he was too busy working. Every day when he looked in the mirror, he saw that he had an enlarged thyroid, but he figured it would take care of itself. As he put it, “It didn’t take a clinician to tell me that something was not right.” It seems that for many, work overshadows personal life until one’s personal life gets to a point when it actually becomes painful to work.

Bill explained that not denying that he had cancer was the right way for him to deal with the disease. He discussed how his feelings, good or bad, were just feelings and feelings are not fatal. Feelings of anger, depression, and happiness would not kill him. The point he made was that he believed it is important for a person to be in touch with ones’ feelings. A person needs to be able to feel again, and life after cancer is one of trying to become a whole person again. Bill said that what really helped him during his recovery was to get in touch with his center, his core:

> The kind of core that makes me tick and what allows me to be connected to you, to others, and through my senses and feelings. That has been powerful and I would imagine that really is what buoyed me up and carried me through . . . unconsciously actually . . . the whole cancer routine and ordeal and being able to talk about it and letting whatever surfaces surface and being okay with what feelings I have. (Bill)

Bill believed that he could eventually work through anything; the operative word is *through*, not *around*. Imagine trying to make your way through a stranger's house at night while the electricity is off. All doors are closed and the rooms are dark. First, you have to be strong enough to open the door and then have the confidence and belief that you will emerge on the other side. Of course, it is frightening and painful to enter an experience for the first time, but knowing that it is temporary is helpful. It helps to believe that there is relief at the other side.

The snare of denial can capture family members as well. Even though it was Samantha's younger sister Sonya who was dying from cancer, Samantha's older sister kept denying that Sonya was ill. This continued denial eventually turned in to anger against Samantha because her older sister kept teller her that her pessimism was releasing negative vibrations out into the atmosphere. In fact, Samantha's older sister told her that she should expect Sonya to be well again. Unfortunately, Sonya did not get better:

> And so it was. . . . it came as a real shock to her when Sonya passed away. So, that impacted our relationship, too. I think that cancer has a ripple effect and not just the lives of the person who has it, but the person who . . . the people who love that person. (Samantha)

For many cancer victims, a cancer journey never ends; there will be many more doors to go through. Even though your cancer may seem to be gone, who can be definite? There are no certainties, and the next time you get a headache or have a slight pain, is your first thought cancer? Even though your body may have healed, emotional healing takes much longer. Time cannot be bottled, placed on a shelf, and retrieved when desired. One of the things you learn early on is that you must take each day one day at a time. This is another gift of cancer. A journey of a thousand miles starts with placing one foot in front of the other. The road to recovery is the same way: Work with today and worry less about what will happen tomorrow. Basic survival is getting from point A to point B.

As Jennifer's doctor told her about her colon cancer, Jennifer too put on her protective gear, not only denying that anything was wrong but also not allowing anyone to see that she was upset.

> He told me that and I was thinking, what . . . you know, this can't be, you know. But I remember I did not . . . there was not any crying, wailing and gnashing of teeth kind of thing. It was just kind of direct and I was upset on the inside, but I don't think he knew that I was as upset as I was. (Jennifer)

For Stephanie, a major concern was the possibility that the result of surgery would greatly alter her physical appearance. Thus, she took her time to seek out several opinions before making a final decision. Not only was Stephanie apprehensive about possibly losing her breast; she also had a low threshold for pain.

> Well I didn't want to lose my body parts. I mean that was a big deal to me. I did not want to lose it. And if I could avoid it, I wanted to. (Stephanie)

When people are in denial or practicing avoidance behavior, such as when they deny treatment or assistance, they are actually placing their health and life in greater danger. Fragile people, such as those who are having difficulty emotionally, socially, or spiritually are actually hurting themselves when they turn away from those who can help them. Mary told us that you need to forget about cleaning your house; you should save your energy for the important things you need to do, and most importantly she said, "You gotta get used to asking people for help."

Jennifer discussed how she always felt bad when she had to ask for help. This was something that she had to struggle with and overcome. She wanted her independence, as she put it, " 'cause I don't want to ask anybody to do anything, 'cause I just want to do it myself." This is also part of the need for control that people want, but as Jennifer said, "Once you have had cancer, one of the things you definitely learn is that you're not in control." Learning how to let go of the control and to allow others to help her was a hard lesson to learn, but cancer can be a wonderful teacher.

Prolonged denial or avoidance of reality is not helpful. However, denial or avoidance, if used temporarily can be a positive emotional tool because it allows a person to piecemeal segments of his or her back together. Even though the scars from surgery are healed, emotional healing takes much longer, sometimes a lifetime. It seems that healthy denial or repression makes room for hope, and it is this hope for a better a quality of life that cancer survivors seek. As Norman Cousins (1989) said, "Don't deny the diagnosis. Try to defy the verdict" (p. 83). In other words, accept what you have, but then use all of the tools that are available to ensure survival, enhanced health, and healing.

In addition to denial, some people respond with guilt, panic, depression, or anger. Anger is a common response to a cancer diagnosis. It is natural to be upset over something that has the potential to complicate your daily existence as well as threaten disfigurement or death. You may lash out and say that life is unfair. As you travel the cancer journey, it is easy to feel as though everything is against you. You are now entangled in the web of treatments and appointments. In addition, you miss opportunities with friends and family as well as work. Who would not be angry about being sick and tired? However, like most things in life, anger can hurt you or help you, depending on what you do with it.

Erin mentioned how one needs to recognize one's anger and then learn how to manage the anger. One should examine the cause of the anger, work on eliminating the cause, and then let it go. If you do not let it go, it can become a distraction and in turn can create a loss of focus on what is important, namely getting healthy. As Erin put it, "Once you learn to deal with it, uh, it just makes it a whole lot easier." However, learning how to deal with anger is not easy.

Unlike time, anger can be stored up like water in a bottle. It is best to discuss the anger with those with whom you having trusting and loving relationships. These are individuals who care for you and love you. You need to find healthy ways to vent your anger but not to the point that it creates interpersonal tension. There is a positive side to anger. Anger has the ability to motivate individuals so they feel empowered to do something about their situation. For example, if you are angry about a certain diagnosis, which was the situation for many of the participants, you can seek a second and third opinion. You can also be motivated to seek alternative treatments and therapies as well to help others avoid what you have experienced.

For Erin, anger was not a helpful coping mechanism. She was in fact angry about her diagnosis and prognosis but she decided to put her energies where they would do her the most good:

> I didn't need to go there. I probably didn't express as much anger as I might or should have, but I decided conscientiously that that wasn't gonna be helpful for me. You need to recognize that there is some anger there that you need to bring to the surface and let go, so you don't want to just let it go and not deal with it. You need to deal with it, but then let it go. Anger can be a distraction. Once you learn to deal with it, it just makes it a whole lot easier. (Erin)

An illness often disrupts important relationships, and others may start to avoid you because of your illness. When this happens, you may lose your sense of self and your connection with others. In addition, you may feel angry with yourself as well as with your higher power. You may feel cheated and outraged; "Why me?" and "Why now?"

Why did your higher power allow this to happen to you? You may say to yourself, "I have played by the rules my whole life, and now I get cancer?" You may begin to challenge your spiritual beliefs as well as question your faith.

Once diagnosed, many participants felt that searching for information helped them cope with the disease. Searching strategies included use of the Internet, talking with friends and relatives who knew people who had had cancer, reading journal articles, and talking with medical professionals. For some, information gathering was a strategy used to alleviate stress and anxiety, while others wanted to know little about their disease. Since all of the participants were academic professionals, access to resources and retrieval of information was not an obstacle. A few participants found the information to be unpleasant and upsetting; others were able to develop a positive outlook toward their treatment and recovery.

Samantha's strategy was to learn as much as she could about her disease. She decided to take a few days off and rent a place at the beach. Armed with a laptop computer, Internet service provider, medical books, and medical journals, she and her husband spent four days learning as much as they could about cancer. Through the Internet, they were able to learn more about her surgeon, the medical facility, and the selected course of treatment.

> We just got to where we knew more than anybody needs to know about cancer and those surgeries that I was gonna go through. [Laughs] I was probably a little over the top, but, actually, but we felt more in control that way. (Samantha)

By having this sense of control over what happens to you, a difficult experience can be a bit easier to deal with. You are no longer totally at the mercy of others. However, it is important that you understand what is under your control and what is not.

You should not become obsessed with control, but rather make sure that you have a plan for treatment that you believe in, that is doable, and that will provide the best possible outcomes.

Several of the breast cancer participants said *The Breast Book* by Dr. Susan Love was of great value. Not only did this book have wonderful pictures; it also provided valuable information for understanding this disease. Erin cautioned that reading this and other books at night was not conducive to a good night's sleep. She mentioned that after a long and trying day, reading about breast cancer created a stirring in her brain that made it hard for her to go to sleep:

> So I can remember just slamming books shut, you know, in bed and say whew, can't go to sleep, thinking about dying. I had enough information and I knew what was gonna happen. I knew what I could expect, for the most part, but not so much that I was just obsessed with it. (Erin)

Erin researched a topic until she believed she had enough information. Thus, when one of her doctors mentioned a new term or procedure, she would look it up. However, it was easy, she said, to get too much information. In fact, Erin got to a point when she had information overload. When this happened, Erin decided to research less and concentrate more on her spiritual health:

> My spiritual health was more important to me at that point in time, because I had developed a good trust with these doctors and felt like I needed to partner with them. I would take the lead on making those decisions that needed to be made, but I would really work with them and the knowledge that they had regarding what was best. (Erin)

Not only did Erin have to decide on how much information she could handle; she also had to decide how much she would share with her family. Since no two people or no two families deal with cancer in exactly the same way, individual strategies become necessary. Everyone in the family, including small children, should have accurate information about the diagnosis and treatment. Children are great lie detectors; they can tell when things are not quite right. When they are not given information, they will come up with their own conclusions, which may be even worse than the truth. The parents need to decide how much information will be shared and when. Through this sharing of information, each family member can then decide what he or she can and cannot do. Each family member can now play an active role to help the sick person work through the cancer experience. Erin's "big" cancer surgery, a complete mastectomy and reconstruction, was scheduled a few days after Christmas. She decided to be selective as to when she would share the information with each son. Her high school junior son was first, then her son who was in college, and then her 8-year-old son.

> We told him first, because we knew he'd hear us talking sooner or later and just wanted to make sure he had all the information. We tried to be very hopeful and just deal with it as it came. Then we told our oldest son, who was in first year at college, after his exams, feeling like we didn't need to . . . and he was already aware that there was something and uh, not surprised, but appreciated us not weighing him down with the information. And then we waited until the day after Christmas to tell our 8-year-old, so that, you know, he had enough time to ask questions, but not, you know, completely put a wet blanket over Christmas. (Erin)

Erin believed that sharing her illness, her plan for recovery, and her progress would be an important lesson for her children to learn how to deal with a crisis in a positive manner. Cancer is not a one-time event but rather a process that may continue for several months or years. Loved ones, especially children, will require updated information as necessary so they may feel that they are still in the family loop.

One of the responsibilities of a teacher is to share information. Several participants mentioned that it was important for them to share personal information about their pending treatment with their students. The purpose of the direct communication was to let students hear directly from the horse's mouth in order to avoid any misinformation;

as Mark Twain was quoted as saying, "The rumors of my death have been greatly exaggerated."

When Eddie realized that he had to have chemotherapy at the end of spring semester, he sent the following e-mail to his students:

> You know, just in the spirit of my belief that the rumor mill is almost always worse than the truth, I just want you know that I'm am going to have to do chemotherapy, it doesn't mean anything terrible but I just have to do it, and I just want you to know because I don't want you to hear stories about me that will probably be much worse than truth. (Eddie)

Eddie mentioned that many of his students responded with appreciation for his openness and sharing. Having cancer is not easy, and knowing someone who has the disease is not easy either. However, through the spirit of sharing, one can avoid the frustration of misinformation.

As far as information gathering was concerned, Jennifer did not want to know anything about her disease or its treatment. Even though she was diagnosed long before the advent of the Internet, there were still resources available to her. However, Jennifer's way of coping was to do nothing because she believed she was going to die anyway. For a dying person, disengagement from others is common. Some of the underlying causes for disengagement are depression, grief, and crisis. Jennifer's crisis was her colon cancer. When I queried her if she had done any research on her disease, she was adamant in her response.

> No. No. No. No. No, I did not. I was withdrawn, just a little lump on the bed. All these people were coming to visit. I did not want to see anybody, so I feigned sleep a lot, even when I wasn't asleep. I'm a reader. I did not read. The television was playing as background. I was not looking at television. I was just there and no, I did not do any research. I did not do anything, because I figured I was gonna die. (Jennifer)

Another coping mechanism that was mentioned was the need to get back to normal activities as promptly as possible so you can start to feel like a whole person again. Cancer is unique in that it does not leave you as it found you, physically, mentally, or spiritually. What you were capable of before, you may not be capable now. One has to set realistic goals knowing one's strengths and limitations. Several participants mentioned that accomplishing a physical task such as riding a bike, working in the garden, or digging a ditch represented a major accomplishment and was an indication that they were not only coping with their disease, but also were moving forward with their lives.

One of Eddie's major accomplishments during his recovery was the digging of a drain field at his home. He could have paid someone to dig this drain, but he wanted to challenge himself, to prove to himself that he was strong enough to do the work. The work was going to be hard since the ground was dry and rocky from a lack of rainfall. In addition to the tough ground, the daytime temperature during the month of July hovered in the high 90s. It was not the digging of the drain that was important, but the fact Eddie could do it:

> It was a way of saying to myself, well, you've been weak but now you're strong again. You know, you're back on the road to being strong again. And that was important to me to do that. But that was entirely just me. You know I didn't really share that with anybody much. I really wanted to just feel strong again. I wanted to feel capable of doing those kinds of exertions again. (Eddie)

In conclusion, having a spiritual belief, a positive mindset, social and personal support, and a willingness to accept the disease as part of one's existence are effective coping strategies for dealing with cancer.

Sub Theme – Self Talk

Overcoming cancer is no minor accomplishment. One has to have the endurance for the long haul. Even though the numerous types of cancers have commonalities in terms of their composition and development, each person's diagnosis, response, and treatment is unique. No two cancer experiences are exactly the same. The fight against cancer is on many levels: federal, state, local, and personal. At the core of the cancer diagnosis is the personal battle, one struggle at a time.

A person with a cancer diagnosis needs time to process, grieve, absorb, gather information, and make decisions. Even though each cancer victim travels a unique journey, cancer sufferers share several common fundamental elements. These include the various ways people cope with their illness. Coping, for example, is an isolated as well as a shared experience. The shared experiences include communicating with family and friends and figuring out what to do about work and money. The isolated experience of coming face to face with a life-threatening illness leads to an acute awareness of one's own mortality. One may begin to feel guilt or shame about missed opportunities, prior choices, and things not finished. Reflection and self-talk are coping mechanisms that allow an individual to better understand why he or she responded in a particular way. Through enhanced understanding, one can learn how to be more effective with one's own personal battle and to gain strength and support.

Self-talk is an internal monologue, a talking to oneself. Since the mind has incredible power over the body, the dialogue between the two can influence emotions and behaviors. No matter how bad you may feel, you can affect your body with your thoughts. Since one's interpretation of a given situation creates emotion, an individual can choose how to define that situation. Many situations in life are stress-producing, but it is how one decides to interpret a situation that determines whether it is stressful or not.

Norman Vincent Peale (1956) said that if you want to have a life full of joy and satisfaction, a change in mental attitude is required. The premise of Peale's *The Power of Positive Thinking* is the belief that thoughts, positive or negative, affect behavior. Peale wrote, "Words have profound suggestive power, and there is healing in saying them" (p. 23). Thus, if a person internalizes negative thoughts such as "This is going to be hard" or "I cannot do this," then the thought process will cause the body to react negatively. In contrast using positive words such as "I can do this" or "I feel good today" will produce a positive thought process. These positive messages can help create positive actions.

People who are positive thinkers have an advantage over people who think negatively: "Nothing is either good or bad, but thinking it makes it so" (Harbage,1971, p. 946). In other words, nothing is inherently good or bad in and of itself but can become good or bad through our interpretations and actions, which produce positive or negative behaviors and outcomes.

Through self-talk, we can help ourselves turn an unpleasant situation in to a positive opportunity. Self-talk, which is a learned skill, can improve with practice. Positive self-talk can help one manage the damage an illness creates by creating a positive image of how one sees him- or herself in the future. Positive self-talk has the ability to enhance relationships with others as well as with oneself. The benefits of improved self-talk include enhanced self-esteem, an improved outlook on life, and enriched relationships.

Louise Hay (1987) asserted that every illness that lives within us is created by us. Hay said that our body is a mirror image of our inner thoughts and beliefs; our body is constantly talking to us and we need to take the time to listen. The reality of a cancer diagnosis stresses the importance of a life pause. A life-threatening illness starts the clock on confusion, shock, disbelief, and a life changed forever.

It seems that when a person receives a medical report, that person reads into it what he or she wants. Bill perceived his PSA result to be just slightly above normal and in his mind; it was due to a statistical variation. After all, he rationalized, the medical community gives us guidelines for weight, blood pressure and so on, but those are guidelines. Since there are so many variables to consider, as long as you are close, you should be okay.

> I had talked myself through and I didn't really think much about the sheet of paper that I got, cause I was just two-tenths of a point over the normal range. So, I was like it's probably nothing. But, it turned out to be something, you know. (Bill)

When Bill talked about his cancer, it was always in the past tense. "Well first of all, I don't think I have cancer, but to have had cancer. . . ." This was an example of positive self-talk. As far Bill was concerned, his cancer was gone. However, there always seem to be two lingering questions: (1) How does a person know when he/she is free of the disease? and (2) When can a person say with any certainty that he/she is cured? Many cancer victims celebrate the magical five-year milestone, and often those who make it to this point feel as though they are probably in the clear. However, doubts and fears about future cancers may linger for years to come. This is due to the problem that people do not understand enough about cancer. How can one know if a particular cancer treatment plan will work if people do not know how cancer works and what causes it?

Often times when one receives bad news, after the initial shock has subsided, one may think, “It could be much worse.” This attitude of looking on the brighter side is self-talk in action. Several participants remarked that cancer is just one of those things that happen. There may be some causes, but for the most part those causes are remote and difficult to determine with certainty.

Eddie talked about how he felt the day before his major surgery, and he nonchalantly remarked that “cancer happens to people every day.” For Eddie, getting cancer was not a huge surprise since he believed that so many people receive the diagnosis on a daily basis. As he put it, “I’m as good a candidate as anybody.” His opinion may be rare, but he told himself that he should feel lucky, as his diagnosis could have been much worse. He shared this story to illustrate his point.

Imagine arriving home one evening and you realize that a burglary has occurred. At first you become angry and mad and say to yourself, “I would do anything I could to catch those guys.” However, as you walk around and survey the damage, straightening the furniture and putting things back in place, you keep saying, “It could have been much worse.” Your dog was not hurt and your family photos were untouched. Yes, there were many items broken, but there were many more items not broken. Again, you remind yourself, “I am glad it is not worse.” This is how Eddie thought of his cancer diagnosis.

Whether an individual lives in fear or joy is up to the individual. As Peale (1956) said, each day when you get up and look in the mirror, only you can decide whether you will wear a happy face or a sad face. Bill and others in this study saw themselves as individuals who had taken control of their situation and moved on with their lives with a positive outlook. They all consciously decided to take better care of themselves, physically, socially, and mentally. It is understood that a healthy mind enhances self-esteem, improving and promoting overall good health. In addition, this enhanced self improves the immune system, which in turn can help protect against future diseases.

When Bill stated that he had had cancer, he was cautious when he spoke about how his cancer could have gone in many directions. He would have to play it out, but a sense of hope was always present:

> There's that sense of hope that has always been a part of my life and so I realize that it could've been traumatic. It could have led to my death, but at the same time, I'm just gonna take this a day at a time and, you know, I'm fine and healthy today. (Bill)

Even though Bill's cancer was in remission, the cancer specter was ever looming. He knew that negative self-talk is not beneficial, and he tried to avoid it. However, he also knew enough about prostate cancer to know that when it metastasizes, it primarily goes to two places: the lungs and hips. Therefore, whenever Bill's hips ached, his immediate thought was cancer, even though his most current PSA test was normal:

> So, the first thing that I think of when my hips ache is, my cancer might've broken loose, and that's where it is. That's the first message. It really doesn't panic me. I don't then act on that. But I have to tell myself, now wait a minute, you just had a PSA test and your PSA test was zero and if those cells were there, they would be speaking, the chemistry would be there. But that's not the first thing that comes to mind. The first thing is this is not a good thing . . . this specter has revisited me. That's the first message that comes when my back aches. So, I do send myself negative messages all the time . . . all the time. (Bill)

We never stop thinking, even at rest. As we think, we have a dialogue with our inner selves. This mini transcriber inside our heads helps us to think critically, but also it helps us to remember the good times as well as the bad times. Unfortunately, it is difficult to permanently erase negative experiences and images. There is a sense that once one has had cancer, it never goes completely away. Every little ache or pain brings thoughts of a recurrence. Is this headache I have a headache or do I have a brain tumor? The image of a cancer victim is not a pleasant image to carry around in one's head. It seems that a person with an incurable disease has constant reminders of the disease. For Eddie, a constant reminder of his thyroid cancer was the tightness he felt around his neck because of his two surgeries.

> You just don't have any moment's rest. You always think about it. Maybe reality is just not that way. I don't worry about cancer every day. I guess there's never a day when I don't remember, you know, some aspect of it. I always have a pain in my neck. I mean I can't move my neck without feeling some discomfort, and that's just always going to be there. (Eddie)

The cancer journey is not an easy one. No one chooses to have cancer. However, having a positive focus on the physical, emotional, and spiritual aspects of life allows this journey to become tolerable. With the help of positive self-talk, Erin was able to make her way through her cancer treatment:

> We can . . . we can cure this. I was like okay, you know, we're gonna have to go through a lot, but we can cure this. And so that was just all I needed to uh, kind of okay, right! We've got hellacious future up ahead, but [laughs] we can cure this. (Erin)

Sometimes our hearts and minds go in different directions and at different rates. In our heart, we know that we want life and that it takes a certain amount of discipline and perseverance. When we think critically about what we have to do in order to continue living, we often become frustrated and angry, especially with the medical community. Lives are still being lost and much pain and suffering experienced in spite of the millions and millions of dollars spent on research. Some refer to the War on Cancer a medical Vietnam. No matter how much money is spent, total victory will never come.

When one receives a cancer diagnosis, surgery, chemotherapy, and radiation are the standard offerings. Surgery is usually the first procedure if the cancer has not metastasized to other parts of the body; chemotherapy attempts to poison the bad cells, and radiation burns them. These conventional treatments are often more hazardous to a cancer sufferer than the disease itself even though alternative, non-toxic therapies are available.

Many cancer sufferers say that the chemotherapy and radiation were much worse than the surgery. Chemotherapy and radiation are painful treatments, and the sometimes outward side effects of looking and feeling bad only make the cancer victim feel worse.

Stephanie approached her upcoming surgery not as a medical procedure but as a healing service. She said to herself, "I went in saying I feel like I'm going into a healing ceremony, not surgery, you know."

Jennifer expressed her frustration about receiving chemotherapy and getting its side effects with negative self-talk. She was in doubt about the benefits of chemotherapy and wondered if she could endure the side effects. One of the problems with the negative self-talk about treatment is that one may actually decide to stop treatment all together.

> They don't know crap about cancer. . . . I mean that's just what I really started coming to and then I was going through. . . . Now do I want to take chemotherapy when they don't know what it's destroying. How do they know the bad stuff from the good stuff that's being destroyed and so I got that I was feeling so bad after the chemo that you're saying is this really worth it, you know, and all that. (Jennifer)

Money spent on research as well as money spent on diagnosis and treatment was another focus of self-talk. The National Cancer Institute (NCI) reported that the President's budget for 2004 was almost $5,000,000,000, and the NCI had requested an increase to almost $6,000,000,000 for 2005 (*NCI Budget Request for Fiscal Year 2005*, 2004). The frustration and in some cases anger for many cancer victims has to do with where the research money is spent. Why is it, they ask, that each year more and more money is spent on research, but what are we finding out? Do we know any more than we did 10 or 20 years ago? Samantha, after experiencing the loss of her younger sister, found it incomprehensible that the medical community did not know more. In fact, she wondered if the medical community did know more but was reluctant to share this information. Could it be, she asked, that the major pharmaceutical companies only promote those medications that have a patent and profit potential?

> I don't know why we don't know more about it. Why do we not know? After the billions and billions of dollars in research money . . . what do we know? We know one thing . . . the only thing we know is how to give a person enough chemicals to bring them just to the point of death, hoping you'll kill the cancer without killing the patient. How to poison a person in an attempt to poison this evil, vile cancer. That's all we know! (Samantha)

Samantha also questioned the lack of research on alternative treatments. Has the medical community allowed enough time for alternative treatments to prove themselves? By the time Samantha had started her own investigation on alternative treatments, it was too late for her sister. In closing, Samantha said that if she were to get cancer, she was not certain she would go the traditional route of surgery, chemotherapy, and radiation. After all, she said, referring to her younger sister, "the traditional route didn't help her at all."

In coping with cancer, the first line of support is often one's family. It is at this time that closeness with family members is critical. Our social nature makes us want to bond with others. Individuals who have experienced the loss of a spouse prior to a cancer diagnosis face an even steeper uphill battle because they no longer have their partners with them. For the cancer survivor, not having a spouse or partner to share emotions and feelings makes the cancer journey even more treacherous.

Even though well-meaning individuals may say that it is time to get back to normal, that you have grieved enough, grieving has no time limit. For the one who is left behind, there is no recovering of what has been lost, only a moving forward with an altered view and way of life.

Both Mary and Valerie lost their husbands prior to their cancer diagnosis. While they think the loss of their spouses might have accelerated the onset of their illness, this is difficult to prove. However, Mary believed that she would not have gotten cancer if her husband had not died. She further believed that if she did get cancer while he was alive, the two of them would have had a successful cancer journey together.

> Had he still been around, I don't think I would've had the cancer if he was around, but we would've worked [laughter] it out. I mean he would come into the operating room with me. (Mary)

You have to realize that you need to take positive steps to better your situation. A disease like cancer does not fix itself; you need to take control of your own situation.

Cancer victims need to do the things that are within their capabilities. The rest will have to be taken care of by someone else. Through positive self-talk, one is able to focus time and energy on the important things that will contribute to better health and a higher quality of life.

Sub Theme – Rituals

As people recover from cancer, they may begin to do activities that are somewhat different from before, or they may even add new activities. Some of the activities in which a person participated before cancer take on a different meaning after cancer and become of significant importance. Cancer survivors talk about how life is short, how little things become big things, and how tomorrow is not a guarantee. There are many lessons from cancer, but probably the most important lesson one learns is to make the most of each day. For some, suffering accelerates the learning that they need in their life to become better people. For others, cancer allows the seeing of life through new eyes and with new behaviors.

Several participants talked about performing specific rituals during and since their cancer diagnosis and treatment. A ritual is often confused with a routine; the two are not the same. The main difference between the two is the significance of the meaning attached to the activity. A ritual, said Mathew Fox (1994), is "the primary means by which a people get their inner houses in order, both as individuals and as a community" (p. 250). The word *routine* is defined as "a customary or regular course of action or procedure" (*Random House College Dictionary*, 1988, p. 1150). Routines might consist of making the bed a certain way and time, performing a specific exercise workout, or brushing one's teeth. Rituals are unique because the time preparing for the ritual is as important as the actual event itself. Examples of family rituals include weddings, funerals, and holiday celebrations. While many rituals involve religion, it is not a requirement. Rituals also represent a paradox, a loss, and a gain at the same time. For example, at a wedding ceremony, the bride's parents mourn the loss of their daughter but at the same time should be happy about gaining an additional family member. Another ritual paradox exists at the death of a loved one.

Cancer survivors, families, and friends can use rituals to provide support and stability during the diagnosis, treatment, and follow-up periods. Since cancer can threaten one's physical being as well as one's ability to maintain relationships with self and others, rituals provide a way to reestablish a connectedness with the self and others.

Humans communicate using symbols, which allows them to reflect on themselves and their bodies and to attach meanings to events. Symbols can also be part of the ritual process. A *symbol* is an object or a sign that can represent something that is invisible, such as a thought or idea. Even though symbols may have an importance all their own, they often lead to things beyond themselves. For example, a handshake is a symbol that says, "I welcome you" or "I trust you." Another symbol is the United States flag. The flag is made of different colored fabric, with stars representing each state. However, the flag is more than red, white, and blue material. The flag represents our country as the home of the free and the brave. For many, the flag is a symbol for freedom and hope. In military funerals, the United States flag is part of the funeral ritual.

For Erin, as a theology teacher, reading Bible scripture was not only part of her teaching but of her personal life as well. She shared how she routinely read her Bible during her personal time at home. However, her routine had become a ritual since her diagnosis. After her diagnosis, she designated a special prayer chair in a designated space in her home. Before her cancer, she often sat in any chair and read, but after diagnosis, scripture reading became a formal practice.

> It has become a ritual of lighting the candle and either reading something or just sitting there praying for other people . . . that became very ritualistic for me. (Erin)

This ritual allows Erin to (a) call on her higher power and (b) restore order in her life. Erin finds great comfort in this ritual.

Not all rituals are religious in nature. Stephanie had a ritual of wearing pearls during her treatment. Magical healing powers have been part of the beauty of pearls. Like cancer experiences, no two pearls are identical. Roman history tells us that women of ancient Rome took pearls to bed with them to sweeten their dreams. In addition, Europeans believed that the powder of the pearl, as well as swallowing it whole, cured matters of the mind and heart and strengthened nerves. Thus, the belief that wearing pearls during treatment could have a positive effect comes as no surprise.

The impetus for Stephanie to wear pearls came from the women in her book club. Several of her book club friends had gone to California for a spiritual health retreat. Part of the retreat included guest speakers on various healing techniques; one session was on the medicinal value of stones. According to the speaker, pearls are supposed to be good for breast health. When Stephanie's friends returned home, they told her about what they had learned about stones and pearls in particular. On Stephanie's next visit to her doctor, she asked her about the wearing of pearls. Her doctor told her that she did not know anything about this. However, Stephanie did notice that her doctor always wore pearls. So Stephanie thought that maybe there was something to this.

Stephanie's book club wanted to do something for her, so they loaned her their pearls. Her collection grew to include necklaces, bracelets, earrings, and broaches. If it had a pearl, Stephanie had it in her possession.

> I had pearl necklaces and earrings and everyday, through all that stuff, I wore pearls and I told everybody why I was doing it and it was just sort of one of those things I could pass on and I think there's a need to hang on to anything that that connects you to something beyond yourself. (Stephanie)

Perhaps it was partly the placebo (Latin for *I will please*) effect (that is, the effect of an object and the subjective importance of that object) coupled with her treatment that made Stephanie a survivor. Stephanie added that her healing was not hers alone, that her faith and belief in being one of God's children gave her the gift of life. Viktor Frankl (1984) said of his experiences in the German *Schutz-Staffel* (SS) camp and the impact faith had on being a prisoner, "The prisoner who had lost faith in the future – his future was doomed. With loss of belief in the future, he also lost his spiritual hold; he let himself decline and became subject to mental and physical decay" (p. 95).

In summary, rituals are social practices with expected outcomes. Rituals provide the appropriate time, space, and environment for the communication either to oneself or to others about one's physical, mental, and spiritual condition.

Research Question 3

How do higher education teachers who have experienced cancer describe teaching and learning after they return to the workplace?

Theme 3 – The Outcomes of Cancer

In this section, the discussion focuses on what cancer can teach us, how cancer can revise one's perspective on life, and the effect cancer can have on teaching.

Sub Theme – Lessons Learned

The world for a cancer victim is unique due to the physical and mental demands of the disease. How a person views life and responds to it can become a vital element in the arrival of a disease, its treatment, and eventual outcome. Many cancer victims carry the scars, both visible and invisible, of their illness for the rest of their lives. Even though surgery may be able to remove the scars permanently, there is often a residue, however slight, of what was once there. The physical pain in the aftermath of cancer for many is tolerable. Pain becomes an unpleasant companion, something to deal with on a daily basis. However, what becomes a greater challenge for many cancer sufferers is the mental aspect of the disease. The question often asked is, "What can I do from this moment forward to avoid this disease?"

Several participants discussed how they believed that certain events triggered or jump-started their disease. For them and many others, it is important not to repeat past behaviors. Cancer has a lot to teach us, and one of the primary lessons is to learn how to get rid of or at least minimize negativity in their lives. An important thing to keep in mind, wrote LeShan (1977), is that "it is possible to be concerned and responsible towards others without sacrificing one's own life" (p. 182). It is this caring for self, that one's life does indeed matter, that becomes the pivotal turning point in one's personal journey toward a life well lived.

Stephanie shared several examples of significant lessons learned. Her first one had to do with not taking every student's problem home with her. Before her cancer journey, she often shouldered every student's burden or problem at work, no matter how trivial. She was the super woman who could handle anything that came her way. However, after her cancer experience, Stephanie began to carry a visual of a shelf with a coat rack behind her head. When a problem or concern came her way, she would mentally say to herself; "Okay, this one goes up here, and that one gets hung over there." The problems were out of her way, and she did not have to look at them anymore. She could get them down if she wanted to or they could stay there for someone else to pull down and fix. She struggled for quite some time trying to let things go, but, she said, "I do it really easily now and it has become second nature."

Even at home, Stephanie had the shelf and coat rack. If she could not go to sleep because she was excited about the work she was doing tomorrow, such as visualizing and planning an event, she would get up, read for a bit, and then "hang the items up" and go right to sleep. Stephanie summed it like this: “It is all about letting go and putting it down and moving on. You can choose to live that way or you can choose not to live that way.”

Stephanie enjoyed sharing the meaningful parts of her story with others. She believed that through her own story telling she was able to build faith in the fact that what she was saying is worth hearing. The act of listening is probably the most important relationship skill a person can develop. It is through listening that one is able to ask questions, expand understanding, search for suggestions, and show that the person speaking matters. For many cancer survivors, there is a constant struggle with one’s self-concept. *Self-concept* is defined by Hafen (1992) as “a broad term to encompass all the ways we compare and evaluate ourselves to those around us” (p. 558). Perhaps this struggle comes from the guilt or shame of cancer, of what the disease has done to us as well as to others. We all want to feel accepted, but we sometimes question whether we are worthy. We are all damaged goods in one respect or another, and we ask, are we good enough as is? It is funny how we all feel the need to be accepted, but we continually reject others. A major illness such as cancer has the power to open a person up to the world’s beauty and to demonstrate the gift of life.

Stephanie hoped that by sharing her cancer journey and the lessons she learned, she would be able to open the eyes of others and show them that they did not have to live the life they were living. Henry David Thoreau (1951) said, “The mass of men lead lives of quiet desperation” (p. 22). I believe he was saying that people need to see and enjoy the beauty of nature and to take joy in the simple pleasures of life. Thoreau wanted to face life in its simplest form and learn what it had to teach. His greatest fear was that when it came time for him to die, he did not want to discover that he had not lived.

Like Thoreau, Stephanie and others in this study also want to make sure that they live a full and satisfying life. However, not only do they want to live a full life; they encourage others to do the same. Life after a cancer diagnosis and treatment is like starting anew. Stephanie said that life is all about making choices, and these choices ground a person's life. From an existential point of view, one always has a choice. Even not making a choice becomes a choice.

> So anyway, I sat down with each of these women in the garden and they told me their story and why they just want to live like this and I said, you don't have to. It's a choice. You know, you wake up every morning. You can choose to participate in all that crap or you can say I refuse it. And that's the kind of thing I think I do now, but kind of wish I'd done it thirty years ago. I could've been a really good teacher [laughs]. (Stephanie)

Stephanie was a wonderful teacher, but she thought that had she learned these lessons earlier, her teaching would have been that much better. Cancer has the ability to stimulate passion in people and to generate personal creativity and growth.

Finally, cancer can be a catalyst to help a person move from point A to point B. Rather than inducing the thought, "I have cancer; my life is over," a cancer journey can provide a person with time to reflect, while at the same time it provides the green light to make needed life adjustments. Life is replete with ever-changing challenges. The choice is not whether one will accept these challenges, but how.

Another lesson cancer teaches us is how to deal with emotionally upsetting events such as the loss of a loved one. Cancer has a way cutting through the fog of life so one can see better how to work through life's constant challenges. Erin shared that her cancer journey taught her how to better handle grief. Having experienced her father's dying and then her own cancer helped her demonstrate to others how to work through the grieving process. I see a parallel in how one grieves and how one manages a cancer diagnosis and treatment. Some grieve openly, sharing their hopes and fears, while others grieve in silence. Fear is a normal human reaction. What we seem to fear the most is what we do not understand. However, once things are upon us, we seem to somehow handle them. There is no one best way to grieve; however, the main point is that the more you prepare, the easier grief becomes to manage.

Erin explained that one of the best lessons she learned from her cancer experience was how to pay attention to how people grieve. Being a minister, helping others through the grieving process was part of what she did. She explained that her cancer experience taught her to ask questions, and more importantly, to seek out answers. Erin did not know whether she was going to live or die, so it became imperative that she show her loved ones how to grieve well. She believed that people who grieve well can live beyond a loved one's death. Erin also said that the opposite also occurs, that is, there is trauma before death, and people spend an enormous amount of energy working through that before they can arrive at any kind of peace.

Some people choose not to grieve at all, pretending that it does not matter. Erin said, "I think grief does matter and the lesson of attending to people before you die makes all the difference in how they will live on."

I believe how we die really needs to be a reflection of how we live. One needs to pay attention to how one lives, and chances are that how you die will be similar and will make a lasting effect on those who are left behind. What gave Erin comfort during her cancer journey was that she taught her family how to grieve well; she said, "I think that's what kept me from being so concerned about my children." For Erin, learning how to grieve and then sharing that lesson with her family made a world of difference in how she managed her cancer journey.

Cancer can teach us a lot about others and ourselves, but one has to be at that teachable moment in his/her life. We need to be open and willing to learn from the lessons that make their presence. I believe there are many people who come through cancer with no lessons learned. They do not tell anybody that they have the disease; they put on hats and wigs so no one will know that the hair is gone, and they will miss work but never cite the real reason for the absence. Once treatment is finished, they are back doing everything they did before and continue to behave as though nothing has changed. Even if the cancer survivor looks the same, that person is certainly quite different. The crisis of cancer allows one is able to grow and to share that growth with others. Sharing helps everyone, both the ones who give as well as the ones who receive.

One of things cancer does is that it teaches us how we can talk to others about the disease. Being able to say to a fellow cancer survivor "Been there, done that" automatically creates a much needed connection. Persons with cancer respect each other's experiences; they recognize that having cancer is no small thing. One learns what to say to a newly-diagnosed person to help keep the person from becoming emotionally devastated.

In summary, cancer does not have to be a death sentence. As the participants illustrated, overcoming cancer teaches many lessons and can be the catalyst for new beginnings. The transformation from a person dying from cancer to a person living with cancer speaks loudly to what one can accomplish. One can sit back and let time go, or one can orchestrate how he/she wants to live. Hamilton Jordan (2000) wrote, "Cancer does not have to be a curse . . . it can be an opportunity to gain insight into your life" (p. 33). Cancer teaches many lessons, not the least of which is to learn and to live one day at a time.

Sub Theme – Perspectives Revised

Many of us live in a "drive thru" world, and the saying "You are what you eat" tells us that perhaps we have become fast, cheap, and easy. After cancer treatment, many cancer survivors want to find ways to reduce the recurrence of the disease. Having this new lease on life, survivors reflect on the possible causal factors and take a thoughtful look at diet, stressors, and exposure to chemicals. Oliver Wendell Holmes said, "What lies behind us and what lies before us are tiny matters compared to what lies within us" (Covey, 1990, p. 96). These words tell us that no matter what has gone on in the past, and no matter what we have to face in the future, we are going to make it. It is one's inner strength that helps to determine one's outcome. This examination of within becomes a time when people look at how they take care of themselves and their health. They need to learn how to listen to and trust their inner voice. For many survivors, this marks a significant turning point for living a healthier life. One can still be ill but feel good. Even though making changes is no guarantee of forestalling a recurrence, these changes can help you feel better and lower the risk for other health problems.

Cancer survivors often try to understand what having had cancer means to their lives now. Many survivors have found that the cancer journey has caused them to look at life differently. These new looks may be upon their spirituality, their purpose in life, and what they value the most. While many survivors feel fortunate or blessed to have made it through the treatment and now view life in a more positive way, some still have negative feelings. Negative thoughts and emotions feed on themselves. This negativity can come from fear and anxiety, which tend to suppress one's immune system. A suppressed immune system makes a person a vulnerable target for disease. Stress and negativity are counterproductive to the healing process. There is no denying that stress is a part of life, but people need to put up their stress deflectors like a Roman shield so that the stress is not absorbed.

Cancer never leaves people exactly how it found them. Most survivors make changes in their lives to reflect what matters most to them. For example, one may spend less time at work and more time with family and friends. Beating cancer gives a person power and pride that can carry over to other aspects of life.

Our world consists of five-year plans, Personal Digital Assistants, and financial portfolios. Even having lunch with some one has different connotations than in the past. We no longer spend time talking about our lives but we "do" lunch. Even the concept of time has changed. Time, which once seemed to be flexible, has grown elusive and rigid. Many people pay others to do errands and chores in order to save time. In reality, what we are doing is swapping one activity for another, and as a society, we seem to be running out of time. No longer do we simply spend time with our friends and family; we now talk about spending "quality time." Quality time is the time one spends with people they love and respect. Usually quality time is time spent doing fun things that are not work related. Since the time spent is compressed, like a power nap, the time spent is intensified. We seem to rationalize that spending 10 minutes of quality time is better than spending an hour with someone. In fact, there is a software product called "Quality Time" that monitors the amount of time each family member spends on the computer.

The purpose of the software program is to solve arguments over computer usage. It does this by limiting computer usage to particular times of the day.

For cancer survivors, the time starts ticking the moment they receive the diagnosis. They now begin the journey of the art and science of cancer. Life seems to be at a standstill, but actually, time does not stop for anyone. Time is precious. Time is the one thing cancer survivors need most, time to be heard, time to understand, time to be reassured, and time to heal. Suddenly one has to devote 100% of his/her energy to something that person probably never thought twice about before.

As discussed earlier, the stress of life can have negative effects on one's health. Samantha was always an over-achiever, and her mode of operation for years was, "I've gotta do this, I've gotta do that, I've gotta do the other thing." As a result of her sister's death, Samantha found that time you could have spent with someone "is gone before you know it."

Samantha explained that like everything else in life, you do not always know what is going to happen. She said, "Cancer is a terrible thing and I could have it tomorrow." As she reflected on her sister's death and her life with her husband and son, I could feel the effects that cancer had on her. Thoughts about cancer made a significant impact on how she viewed life and how she planned to live her life. There was a greater emphasis on her family and friends. One thing she was adamant about was spending more time with her son. One example she shared was how she had always taught on Wednesday nights while her son's youth group met on the same night. She said, "I always thought well, he's good. He'll be there and I'll be in class." However, as she reflected on their separation and how they were not spending time together, she decided to switch her class to Monday. By switching to Monday night, she was able to be more involved with him and his youth group.

Samantha also realized that her son had only four more years before he would be out of high school and gone to college. Prior to her sister's death and her husband's cancer diagnosis, Samantha was always willing to participate in a workshop, handle any academic request that came her way, or write an article or even a chapter for a book. When asked, her standard reply was, "sure." After her sister's death, with her revised perspective on the briefness of life, she began to think twice before she said "yes." In fact, her response became, "I am sorry. I am not interested in that because I want to spend more time with my family." I believe that cancer has a way of helping people say no, in a nice way, to things they do not want to do.

There is a wonderful sense of empowerment in saying no. Saying yes is much easier, since when people say no, they open themselves to confrontation and anxiety. However, cancer survivors should learn about how to establish boundaries as well as how to set limits on their time and abilities. Most people will understand and respect a person's boundaries if they know about them. As Samantha told us, she wanted to limit herself to those relationships and activities that supported her goals. No longer was she an automatic people pleaser, always being agreeable to keep others happy.

Like others in the study, Samantha had difficulties trying to weed out the good from the bad. When grief comes your way, what are you supposed to do? Even though it was her younger sister who died from cancer, her husband was now dealing with the disease. Cancer had taken her sister; was her husband the next victim? She said, "You are always waiting for the other shoe to drop." Even though her husband seems to be in good health, he is just "not himself." Part of the frustration is that his doctors are not able to pinpoint the cause. As she put it, "There's always that feeling that your life is in limbo."

No one of us knows exactly what tomorrow will bring, but many cancer victims and those affected begin to simplify their lives. Samantha decided that after the loss of her sister and the questionable health of her husband, she needed to simplify her life. She thought that if her husband became ill, she now would have to take care of him and her son. She would need to be able to take immediate action and thus be in a position where she was not overly obligated with work responsibilities. These past events crystallized her priorities. Samantha believed that for the most part, the medical community is in the dark about the causes and cures for cancer. Samantha's first-hand experiences became, as she put it, "scary"; it was this fear of the unknown that caused her to live a life that was in a constant state of limbo. She concluded by saying, "You can't live that way, but you also have to be realistic that something might happen." Levine (2001) wrote that "Disease may score a direct hit on only one member of a family, but the shrapnel tears the flesh of the others" (p. 103). Samantha's revised perspectives on living are certainly a testimony to what Levine said. What I sensed from Samantha, in spite of the stress of her sister's illness and ultimate death and now her husband's diagnosis, was the overwhelming positive feeling she received from "being there." I believe that doing everything one can do for a loved one who is ill far outweighs the stress and burden of the one doing the caring.

The onset of cancer and its treatment was not the only thing that was happening in the lives of the participants in this study. They were active in their professional lives as well as in their personal lives. Life does not come to a standstill with a cancer diagnosis, but it does add another layer or a new dimension. None of the participants gave in to cancer, but they rearranged their lives to deal with it. Cancer brings things into focus while providing a time for reflection and self-examination. In other words, cancer allows one to perform a life audit. This audit can ask questions such as, Am I happy? Does my life have purpose? Are relationships the best they can be? Am I living the life I should be living? And so on.

Often people wait for things to happen rather than make them happen. My father often told me that if you want things in life, you have to make them happen. You cannot sit by the phone and wait for it to ring. Cancer survivors come to realize that life is precious and every hour should be as joyful as possible. Erin shared several examples of how cancer has revised her perspectives on life. She believed that cancer can be the wakeup call that many people need, but she cautioned, "It might eventually ring, but you might be dead by the time it rings, so get up and make the phone call yourself."

Cancer can be the impetus to make things happen, not only to you, but to others as well. The frustration for many cancer survivors is how they can get the message to non-cancer survivors that they do not need to hold onto everything. Again, Erin shared that she had a tough time with her husband in this area. While Erin believed that the two of them were opposites, like many couples, that is why they were attracted to one another; however it is this lack of "clickability" that has created pain, heartache, and frustration. They did and viewed things differently from each other; it was apparent from listening to Erin that she had become adept at letting things go while her husband held onto them. Erin said,

> I've made the mistake of saying to him that you keep a score sheet, not only on me, but the children, other people . . . his parents do, so I see it in them and

> recognize that maybe that's where he gets part of this. I mean and it's even harder to deal with me, because I'm not gonna let it bother me. I want to say to him, you don't need to have cancer to get this. (Erin)

Erin wanted people in her world to put a stop to the fussing over the little things, to limit the amount of time spent on micromanaging others, and to do things now. Procrastination was no longer an active word in Erin's vocabulary. Since her cancer experience, Erin had taken on a new sense of urgency and an attitude of "do things now." Another example of her do things now attitude surrounded the discussion she and her husband had about having a lake house for their retirement years. He wanted to wait, but Erin wanted it now because she said, "It could be that I won't live to retirement. Can we go ahead and get this now? So, we stretched ourselves as far as we can and I'll probably be destitute if I do live to retirement, but anyways, we bought that house."

In summary, people need to live their lives. You should not wait until things settle down to do the things you really care about doing. Cancer survivors often mention how life is precious and how we are only here for a short time. The message is clear: Seize the opportunities that present themselves. John Lennon wrote in the song Beautiful Boy (Darling Boy), "Life is what happens to you while you are busy making other plans" (Lennon, 1980). I believe that things happen in people's lives that are out of their direct control, and they should do the best they can with what they are given. It would certainly be a shame if their pain and suffering were to go to waste.

Sub Theme – Teaching and Learning Now

The National Cancer Institute (NCI) reported that "cancer survivors who continue to work are as productive on the job as other workers" (National Cancer Institute (U.S.), 2002, p. 78). For many cancer survivors, getting back to work as soon as possible becomes a turning point in their recovery process. When I thought about this sub theme, I wondered if a person's teaching and learning was any different after cancer. Does the experience of cancer affect how one teaches and learns? Are you the same teacher as you were before you had cancer? If you are the same, how are you the same, and if you are not the same, what is different now?

Each participant shared that his or her teaching and learning had undergone a metamorphosis; some participants had specific examples to share, while others just felt that they were different. Jennifer could not think of any concrete examples but said with certainty, "I know that I am a different kind of teacher because of my experience with cancer." It seemed that for some it was difficult to separate the effects of an illness on their life and the effects of other life experiences due to aging and maturity. Eddie put it like this: "I don't know if I've changed because of cancer or just because I'm getting older or whatever."

Even though working during cancer treatment was difficult, each participant made it a point to prepare in some way for the challenges that lay before them. For example, several participants scheduled their surgery and treatment during a school break. Some participated in team teaching, while others developed alternative forms of delivery such as the use of video or online delivery. None of the participants said that they were not returning to teaching because of their cancer. The consensus was that teaching did not cause their cancer, so why should they not return to what they love doing? Bill spoke for all of the participants when he said, "There was never any issue of not going back." The only fear some shared was that the cancer and its treatment might limit what they could do physically in the classroom.

None of the participants mentioned any pressure from their supervisors or from other faculty members to do more than they could manage. Bill mentioned that his "chair was supportive and understanding." In addition, even though Bill was only six weeks post his prostate surgery, he told his chair that he was ready to teach again. Bill made arrangements so that in the event that he was not physically present during the first two weeks of the class he could teach via online delivery. Bill bought a digital camera and worked with the Information Technology staff so he could have the class in synchronous mode. Bill had put everything in place. He said he never thought that he would not teach the course, but that he "might not be up to teaching the first week or two of it, 'cause it was so immediately after surgery." However, none of this was relevant because he felt quite comfortable driving to and from campus.

For Bill two things were different about his teaching. One was that he sat more in class, using his computer and projection equipment instead of writing on the board. This was quite a change for him as he said, "I never sit during class." Bill felt obliged to share with his students the change in his style but assured them that, "I'm okay. I'm able to teach." The second thing that was different was his reduced stamina. However, Bill was confident that through his thorough preparation he would "bring the class to completion one way or another." He discovered that with his reduced stamina, he found himself interjecting less then he normally would. As he shared his initial return to teaching, he thought that his interjecting less was maybe a good thing. "I struggle anyway with saying too much." Bill found that by his talking less and the students more, his students were able to relate the material more "to their work and their life." Bill saw this as a good thing. Through Bill's experiences, it was clear that supervisors and colleagues wanted nothing more than for all the participants to have a full recovery and to return when they were comfortable.

The shrapnel of cancer also affected Samantha's teaching. She had been teaching for a long time and had worked out the bugs in all her courses, although every semester there was always some improvement or enhancement to make. During the summer after her sister's death, Samantha reflected on her teaching and began to review her courses. She believed that she had pretty much taken care of everything that her students needed to cover.

However, Samantha began to realize that what she had done over the years was to put more and more and more into her courses. It was no surprise for her to discover the reasons why she "was really frantic to cover everything." Thus, she began to reorganize and streamline her courses. She explained that she started to delete "whole parts that aren't all that necessary." Teachers have a tendency to cram too much into a course, and she believed that her students, as future teachers, needed to know everything before they started their own teaching.

Samantha thought, "If I remove this material, where will students learn it?" She then started thinking about her own teaching and learning, and she came to the realization that much of what she had learned was not in the classroom but at workshops and seminars and, as she said, "I learned along the way."

The end result of this process for Samantha was that "I streamlined and simplified my classes even more just in an effort not to feel so frantic about life all the time and in an effort to keep my students from looking like they're feeling so frantic all the time."

Was this a direct result of her sister's and her husband's cancers? It may have been, but it was obvious that she was in the process of weeding things out that were not necessary.

In terms of Samantha's classroom teaching, she said that initially "I just didn't have my heart in it." She mentioned that her students were able to sense this, and in fact, she said that she had received a phone call from the counseling department at the university because one of her students "had ratted me out." This student was calling because she was concerned about Samantha and not about her teaching or the course. The counseling center had called Samantha "just to see how I was doing." Samantha's reaction was, "Oh, my goodness. I did not know it was noticeable to them that I was struggling." As Bill told us earlier, perhaps at the outset there might be a good opportunity to share with everyone what you are going through.

Stephanie mentioned that she began each class with a concept she called Open Connections. This was a time for both the teacher and the student to bring into class whatever they wanted to share about what was going on in their lives. For example, Stephanie would begin by saying, "I'm a cancer survivor. You know, three years ago I was going through cancer this time of year. . . ." One by one the students shared that they were from an alcoholic home, that they were from parents who had married and divorced three times with each other, or that they were concerned about their dad, who was dying of cancer. There were numerous benefits to this activity, but the foundation is that Stephanie and her students had a time for openness and caring. This she said, allowed each person to be a part of a larger community of teachers and learners.

Several of the participants talked about how they had become better advisors to students because of their cancer experience. For example, Eddie said, "I think in that regard I'm a better adviser or friend to students who've had those very serious diseases because my outlook about once you have had that diagnosis is very different." He said that when students shared their own problems, he was more sensitive to their needs. He believed that the most important thing teachers can do is to personalize what teachers expect from their students. I agree with Eddie in that as teachers we must learn how to communicate in a way that shows students we care about what they learn and that they know that we will be there for them. From Eddie's perspective, it is better to be the person that is helping others and caring about others than it is to be one who is not caring about them. I remember the saying, "Students do not care how much you know until they know how much you care."

Stephanie became more passionate and sincere about her teaching. As she put it, "I really work hard one-on-one and I will say that since having cancer, I am even more so." She said that she had shifted from trying to fix people to being more of a listener and a support person. Jennifer, like Eddie, confirmed that the experience of having cancer affected her work in higher education. In terms of her teaching and working with students, Jennifer has become "much more empathic with students, but in a very positive way, so that you don't try to get over the fact that you don't let life's circumstances stop you." I believe that Jennifer was saying that one should not give up but rather work through the things that may cause problems.

Student interactions and relationships became part of new ways of teaching for many of the participants. Teaching became more than lectures and exams. Even though Valerie might have a lecture class of more than 100 students, she made a deliberate attempt to get to know some of her students. She wanted them to be more than a number.

Thus, one of the things she began doing at the end of her class was to ask students to come down and meet her, even if they had nothing to say. As students came to the front of the lecture room, Valerie would say, “Tell me your name.” She would look the student in the eye and shake their hand. This was her way of letting them know that she was interested in them as individuals. Even though Valerie had high expectations for her students, she was serious about her teaching, and she wants each student to be successful. As she put it, “I’m not just there to talk and leave and give them tests that make them feel bad or make them look bad.” As an experienced educator, she knew that there would always be students who would do well with her and others who will fail because “they can’t or won’t get on the horse and ride.” This idea of riding the horse was her way of expressing that students need to be actively engaged in the learning process, no matter how fun or painful. She concluded by remarking about those students who want to learn, “I’m there for them.”

Like most teachers, Mary had high expectations for her students as well. She believed that students could rise to the occasion, given the proper motivation and direction. When Mary talked about the difference in her teaching post cancer, the most concrete example she could provide centered on the quality and timeliness of student work. She explained that in her early years of teaching she would become upset if a student was not doing the kinds of things a good student would do. A good example was late assignments. To her, assignments were due on specific dates, period. Late work was not acceptable. Before her cancer experience, Mary believed that a lack of timeliness on the part of her students was a reflection of her teaching abilities.

I have found that many cancer survivors talk about the fact that before they had cancer, they would take on other people's responsibilities as their own. However, once they reflected on their disease, they no longer wished to be the enablers they once were. This was certainly the situation for Mary. Mary said that over the years she began to "get less crazy" about those kinds of things, and she said it was due to the combination of the tragic loss of her husband followed by her cancer. These two major events have revised her perspectives and priorities, both personal and work.

After being diagnosed with cancer, when Mary received late work, her immediate response was not to say, "Forget it. It's too late," but rather to talk to the student a bit. She intentionally hassled them a little bit, but in the end, she accepted the late work. Mary came to realize that for whatever reason, there are situations that arise that interfere with one's plans. As she said, "After all, they are students and I was a student once, too." As Mary sees it, if a student is going to write a good paper, that student will do a good job either getting the work to her on time or late. A poor paper is still a poor paper, whether it is turned in on time or not, and it is not going to make that much difference in the student's grade. Mary concluded by saying, "I'm not gonna run after you and say hey, you didn't do this paper." The impression I got was that Mary was stepping back from those kinds of issues and leaving the ultimate responsibility up to the student to deliver.

Cancer has ways of making people more human. Many cancer survivors come through the experience with a greater sense of their own and other people's fragility. Bill's cancer experience altered his classroom experiences. He shared that he brought the "humanizing experience of cancer" into the classroom. "I think I'm much more open and flexible and many things that I thought were really important and I was so serious about are not so," and his desire to control outcomes has been reduced considerably. Bill found that he was more encouraging with his students and noticed that he had a stronger sense of self-assurance and security in what he did. I can still see his smile as he proudly said, "I know what I am about and who I am." The spirit of cancer never stops spreading.

Getting back to teaching was something everyone wanted to do. As stated earlier, since teaching did not specifically cause anyone to get cancer, why should anyone not want to return? Getting back as quickly as possible was a priority for Erin. She mentioned reading a book by Henri Nouwen, *Our Greatest Gift: A Meditation on Dying and Caring*. She had read this book during her father's illness, prior to having cancer, and she reread it after she had cancer. According to Erin, Henri Nouwen's unique look at death and human mortality was an inspiration. Erin pointed out that Nouwen said that the greatest gift we bring to those that we love is the gift of who we are. She said, "I'm actually teaching with my life." I gathered from what she said that her teaching was a reflection of her life experiences and she wanted to share her passion for living with as many people as she could. Not only did she want to do this while in the classroom, but also as part of her life outside the classroom. She concluded by stating that this new view had penetrated every part of her soul, and her enthusiasm for sharing has skyrocketed.

The human body tends to move in the direction of its expectations, good or bad. The 17th century scientist Isaac Newton developed a variety of laws to describe motion. His first law of motion states that an object at rest tends to stay at rest and an object in motion tends to stay in motion with the same speed and in the same direction unless acted upon by an unbalanced force. Most people lead productive and enjoyable lives until something like cancer, the unbalanced force, strikes them. This force can come with such a traumatic and instant blow, akin to a boxer's sucker punch, that one can be doubled over in an instant. As the winded boxer struggles to stand, the participants in this study also had to fight their way back into the ring of life.

Even though Valerie was rather weak from her treatment, she had the need to get back to her students. She explained that they "they got a big leather chair that they dragged into the lab" so she could sit there and tell the students what to do, even though she was not fully functional. She shared that she did have a difficult time with that class but it was important to be there. Upon reflection, she said that it was too soon for her because she was not able to think straight, and this caused increased anxiety, which in turn caused her to forget things. In spite of her anxiety, Valerie believed that it was important to her students and to herself for her to be there, to feel a part of things. She never actually stopped working; in fact, she went to work every day because as she concluded, "I didn't know how to stay home."

In summary, the participants found their colleagues, supervisors, and students to be supportive and helpful. This support was important as they continued their professional paths. This support was evident by the way people shared materials and resources, and most of all, their time. I believe that it was this willingness to share and support that helped to allay any fears the participants had about their abilities to be effective teachers. Stephanie spoke for all the participants when she said, "I do think it makes you slow down and live life one day at a time, no matter what." The participants taught me that we could all learn from their experiences. We should realize that we are not responsible for the whole world. We should do the best we can with what we have.

The three major themes developed from the analysis of the data gathered were (a) the nature of cancer, (b) dealing with cancer, and (c) the outcomes of cancer. The first theme looked at what the participants thought of cancer. The second theme provided details about managing the disease. The third theme looked at life post cancer.

The discovered themes and sub themes suggest that despite individual participant differences, there were commonalities in their experiences as they journeyed with their disease. Their experiences certainly affected their lives but also the lives they touched. Each participant's challenge was great, and it is through their individual efforts as well as the support of many others that they were able to move beyond their disease. Even though they all made successful transitions back to teaching, the rebuilding of their lives did not stop there. I conclude that the participants found paths to deal with the realities of their disease and continue to live full lives.

Survivorship of any kind is not easy, and cancer is no exception. Survivors need a supply of psychological tools, such as hope, a positive attitude, and the will and determination to live. However, even with wishful or positive thinking, a person's disease may in fact become worse. When this occurs, one should not feel guilt that he or she has failed. In addition to the psychological tools, one should utilize all of the appropriate advanced technical tools in use by the medical community.

A life-threatening illness makes us aware of how precious life is and at the time of crisis, a sick person needs to mobilize all available resources. If the disease does not kill us, it indeed makes us stronger. Cancer is certainly a test of the body, mind, and spirit. However, it creates time for self-discovery and renewal. It also becomes a wonderful teacher, showing us that the cancer journey is much easier when one knows he or she has a supportive and loving environment. This world is much too big to travel it alone.

CHAPTER 5

DISCUSSION

The purpose of chapter 5 is to provide a summary of the research and reflections on the findings. The topics are: (1) summary of the research, (2) reflections on the themes, (3) summary of reflection on the themes, (4) reflection on the methodology, (5) implications from this study, (6) recommendations for further research, (7) advice from the participants, and (8) personal reflections.

Summary of the Research

The purpose of this study was to explore the theory that higher education teachers who have survived cancer consciously or unconsciously altered their philosophy of education and its implementation. From the analysis and interpretation of the participants' interviews as well as review of relevant literature, three major themes were developed: (1) the nature of cancer, (2) dealing with cancer, and (3) the outcomes of cancer. Using the information gathered and analyzed, each major theme had three subsequent themes that further supported the major themes. When viewed holistically, these themes provided the path to explore the feelings, thoughts, and actions faced by each participant while experiencing cancer. It is my hope that through these descriptions, one is able to have a heightened awareness and understanding of how a cancer experience affects higher education teachers.

This study was an exploration into the lives of eight higher education teachers who had cancer and one higher education teacher who had a sibling die from the disease.

Central to their successful cancer journeys was the presence of resiliency. I view resiliency as the ability to persevere when encountering disruptive moments. Just as a storm-tossed capsized sailboat needs a heavy weight at the bottom of its keel to right itself, an ill person needs a supportive environment to facilitate his or her own personal vertical stability. To be self-righting requires planning, attention, willingness to change, and the faith that a healthy life is possible. Continuing with the sailboat metaphor, many people concentrate on what is above the waterline, ensuring that everything is ship shape and attractive while neglecting what is below the water line. A sailboat would not be suitable for a windward journey if its keel were full of air. Even though many believe that being beautiful on the outside is what matters, in reality the outer covering is simply a vessel that carries us through life. An attractive covering is not sufficient; it is what is inside that counts. A person enhances resiliency by examining, analyzing, and then working on what is beneath the skin's surface. It is through this process that a person begins to realize what he or she cannot do and begins to discover what he or she can do. The ability to move from denying that there was problem to admitting it and then being able to believe that something good may come from these efforts is the foundation for cancer survivorship.

One way of understanding the experiences of individuals is to listen to their stories. Therefore, it was appropriate to use a qualitative approach to give voice to the participants' experiences. Throughout the interviews, there were two important relationship qualities: friendliness and trust. At the conclusion of every interview, the door was open for future conversations. Through semi-structured interviews the data were analyzed according to the principles of grounded theory (Glaser & Strauss, 1967;

Strauss & Corbin, 1998). As a qualitative researcher, I became a generous listener, utilizing my listening and observation skills. By becoming a generous listener, I was able to discover not only the breadth of the experience but the depth as well. Through each participant's words, I gained knowledge about the world as each experienced it. One of the highlights of the interview process was that the participants and I had good feelings toward one another even though we were talking about our life-threatening experiences. I believe these conversations allowed us to deepen our relationships with one another, thus making us feel better about ourselves. Even though I felt as though I may have been intruding into their private world, every conversation ended the same way, with a hug or handshake and a "Hank, I want to thank you for listening." Thus, it was apparent that even though the participants were helping me, I was helping them as well. It is through this spirit of sharing that all can benefit. My overall task was to produce rich narratives of the participants' personal experiences (Coffey & Atkinson, 1996, p. 145). Throughout the data analysis, I continually looked for ways to discover information that would help me develop the findings, which consist of narratives and themes. Interwoven within each participant's profile are individual thoughts about his or her cancer journey.

The one concept that runs throughout this research and connects all of the themes together is the experience of time. Upon further analysis, the time concept appeared more complex, in fact encompassing two dimensions; chronological and phenomenological time. In addition, these two dimensions of time encompass and interact with all the themes and sub themes (see Figure 2).

This revised framework provides the grounding for my theory that I have called *Cancer Time*. The theory of Cancer Time states, "Higher education teachers who have

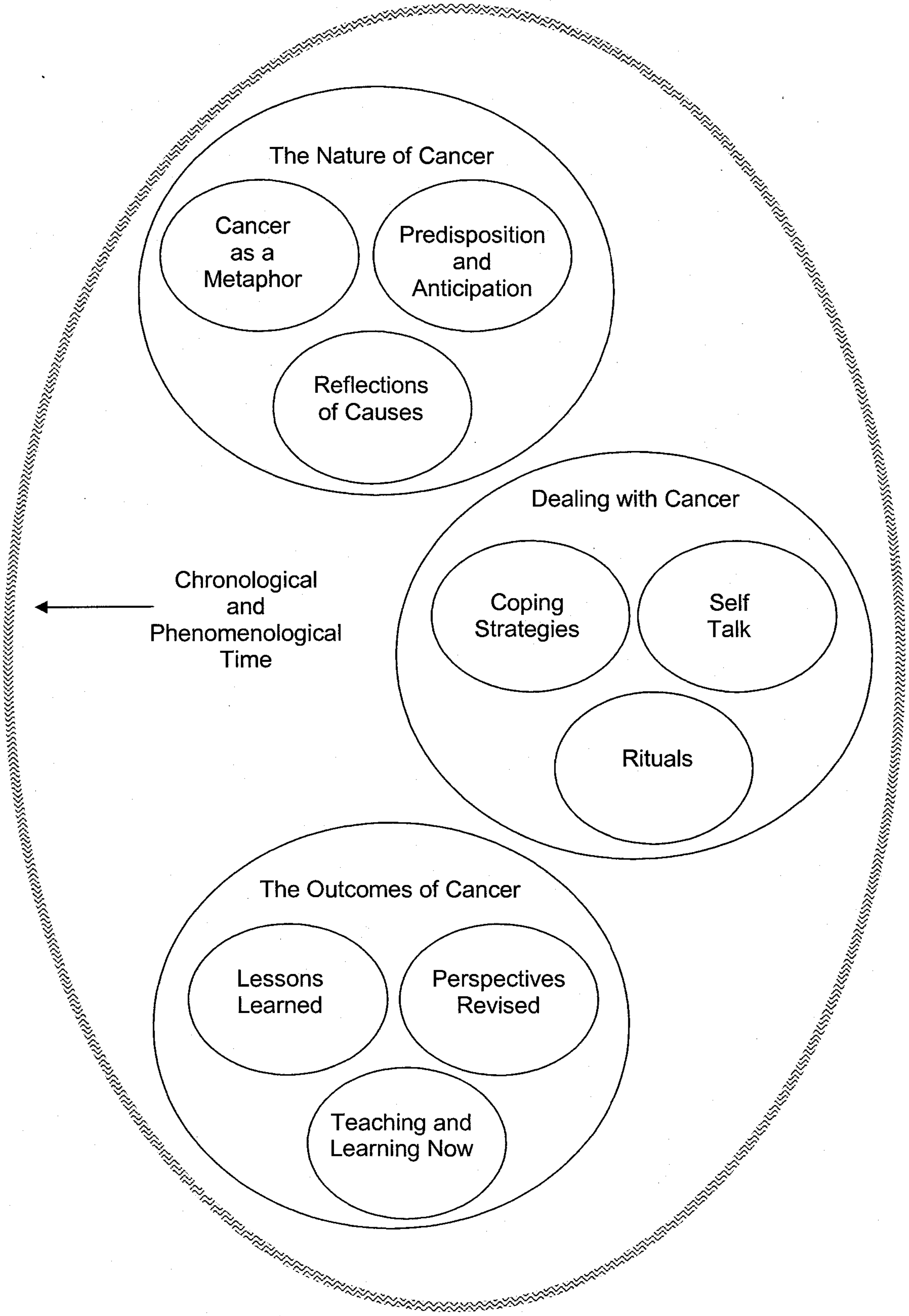

Figure 2. Themes and sub themes.

survived cancer through that experience consciously or unconsciously alter their philosophy of teaching and its implementation." This theory emerged from the continued analysis and interpretation of the data, which can vary, based on who is doing the interpreting and under which circumstances. According to Glaser and Strauss (1967), the user can adjust the theory "to fit the diverse conditions of different social structures" (p. 232). Therefore, grounded theory can be in a general form, and those seeking a more detailed interpretation can apply it to particular situations (Dey, 1999, p. 31). Glaser and Strauss (1967) further wrote that theory must also be "readily understandable to sociologists of any viewpoint, to students and to significant laymen" (p. 3). I believe the theory of Cancer Time meets the requirements set forth by Glaser and Strauss.

Even though it may seem obvious that the experiences of time relate to everything we do in life, I have found the concept of time to be of significant importance to cancer survivors. Van Manen (1990) asked, "What could be more easily grasped than time?" (p. 77). Our lives are broken into time zones. There is time to eat, sleep, work, go to school, and play. We talk about how time has gone by and what great times lay ahead. During the interpretation of time for this research, I have come to think of time as two distinct types of railroad trains. One is the local commuter train, stopping at every station, moving at a snail's pace. The other is a high-speed bullet train with only one stop: its final destination. Van Manen portrayed the time in two ways. There is the pre-reflective lived understanding of the meaning of time, and there is our reflective grasp of the phenomenological structure of the lived meaning of time. I believe that the cancer survivors in this study utilized both of these concepts of time.

My view of Cancer Time includes both the chronological aspect as well as the phenomenological aspect. Roth (2002) discussed the difference between chronological time and phenomenological time. An example of chronological time would be evident if you and I talked about everything that happened yesterday. We would say that we first talked about this topic for 15 minutes, and then this topic for the next 10 minutes, and then something else for so many minutes. During chronological time, we make ourselves aware of the exact amount of time and the passage of that time. Thus, we are constantly measuring the time as it passes. However, with phenomenological time, the timepiece is unnecessary. For example, I might engage myself in an activity that absorbs my complete attention and before I realize it, two hours may pass. I say to myself, “Wow, where did the time go?” It only seemed like five minutes. Thus, we are not aware of the passage of time in a chronological sense. In phenomenological time, we become absorbed in the event. For cancer victims and cancer survivors, the theory of Cancer Time becomes all too real.

Everyone dies. Most people are aware of their own mortality, especially as they get older. I hope that our mortality will not be demonstrated tomorrow. It is, however, imminent. As one reflects on his or her own mortality, one may recall the story of Lazarus in John 11:17 and how Jesus brought a dead man back to life. Even though Lazarus had life once more, many believe that he is not among us today. Of course, the point of the story was not to give life to Lazarus but rather point to the power of God. There are stories from various cultures that describe how persons once “lived” but then continue to live for thousands of years.

Many cancer survivors view cancer as a double-edged sword. One blade represents the joy of surviving while the other blade represents the fear and anxiety associated with the cancer battle. Most survivors of cancer become conscious of the fragility of life and have an appreciation for a new lease on life while at the same time they possess an acute awareness that life can cease quickly.

No one ever forgets a cancer experience. Anxieties and fears about recurrence begin the moment treatment stops. Each person finds ways to cope with the uncertainty of the future, especially with one's health. Cancer might rob us of our innocence that life goes on forever, but as cancer survivors, we know that each day is a gift and we should use that gift wisely and richly.

My research findings suggest that surviving a life-threatening illness affects not only the person diagnosed but also the world in which that person lives. The lived experiences of these participants swelled with emotion as each person faced his or her unique challenges. The survival and healing process goes to the core of the individual. Many of the factors in life like one's health and work, which one often takes for granted, now become uncertain. Returning to a normal life was the goal of each participant. Throughout the cancer journey, each person had to take the time to heal and to process the cancer experience. In addition, this journey also included time to reflect on the world and one's place in that world. All participants had the support of others to help them make their way. It was through this encouragement and confirmation of self-worth that each was able to continue life as a professional educator.

In summary, what is the main message from the participants in this study? They would tell us to continue doing what we love to do, that is, to teach and nurture our students until we cannot do it anymore. Day (1986, p. xvi), using words from George Bernard Shaw, summed it beautifully: “that as educators, teachers should be like candles; aflame, and that they are to burn themselves up, giving light, until the candle flame has been quite utterly extinguished.”

Reflection on the Themes

In order to bring the Cancer Time theory alive, in this section I share the participants’ words in context with the three major themes. In the first theme, *the nature of cancer*, I discuss the following comments: (a) “It was just a matter of time,” (b) “Who has time for all of this waiting?” and (c) “Time never came for . . . .”

Regarding the first comment, I see this view of time as phenomenological time. This person did not count the years and months since birth and then refer to a statistical table that would confirm that it was time to get cancer. Rather, this is one person’s view that a diagnosis of an illness would eventually come, since it seems as though everybody gets a disease eventually. The “Why me?” question, according to Bolen (1996), often arises when one is faced with a life-threatening illness. If the patient somehow believes he or she caused the illness, perhaps it is easier to deal with. However, this is not a good solution; it only doubles the perception of self-victimization: once for getting the disease and a second time for suffering with it. Finding a reason for cancer does not change things. When there is self-blame, coping becomes more difficult. Furthermore, Bolen said that one should not place the blame on oneself since this is non-productive and does not promote healing. When one receives a life-threatening diagnosis, all energy should focus on getting better and not asking why.

The second comment, "Who has time for all of this waiting?" is an example of chronological time. Becoming and being a cancer patient requires being patient. To be patient means to be able to endure waiting or delay without becoming annoyed or upset. Not all cancer patients were true to this definition of patient. All participants mentioned that waiting became a significant annoyance and frustration during their cancer journey. However, this annoyance and frustration was not only with their medical community but also with themselves. Being a cancer patient and being patient are not painless activities. Cancer patients need to have patience and to make the clock their friend.

The third comment, "Time never came for . . . ," the concept of time seems to be a paradox. I view time as a continuum. On the left end is the label *too much* and on the right end is the label *not enough*. Time travels back and forth between these two labels. I view the perspective expressed in this phrase as phenomenological time because people seem to be caught up in the cancer journey and do not always share what is truly on their minds. The time never seems to come to talk about one's hopes and fears, anger and grief. Fear is a normal human reaction, and usually we fear what we do not understand or know. For the recovering person, talk about death and dying is not as significant or as traumatic as it is for the person who has a less than favorable diagnosis and prognosis. Cook and Oltjenbruns (1998) discussed the need for the "dying to deal effectively with their fears and to come to terms with their own grief, they need to know that others still care about them" (p. 45). In addition, when physicians and family members fail to talk openly and truthfully about a person's diagnosis, the situation becomes more stressful for all involved. While it is not easy to talk about death, isolation, and separation from loved ones, one should not experience the guilt of saying "Time never came for . . . ."

In discussing the second major theme, *dealing with cancer*, I address the following comments: (a) "Time for a change." (b) "Time is our friend," and (c) "Time to process."

"Time for a change" indicates awareness that circumstances occur that necessitate a new or revised management strategy. If there is one certainty in life, it is that change is inevitable. I view this comment about change as chronological time. Many people reach a point in their life where they realize they have reached their limit for negativity, neglect, abuse, and other unhealthy behaviors.

Depending on one's skills and experiences, making needed changes can be a fearful experience or it can be a time for celebration and for new beginnings worth embracing. The first step a person needs to take is to become aware of the source of his or her unhealthiness. Many people rarely forget the causes of unhealthy activities or relationships. The next step is to make the difficult choice of eliminating those activities that are no longer healthy. However, as Myss (1996) said, "Changing our lives is often difficult because of our existing loyalties" (p. 53). These loyalties may be to friends, family, or work and may even be misguided or unhealthy. For example, a person may be married to an alcoholic or abusive spouse. Instead of seeking treatment for the alcoholic or filing for divorce, one will endure the unhappiness up to a point. It is at this point, according to Myss, that "our emotional body becomes sufficiently empowered that the mind can no longer fool the heart" (p. 53). Thus, one can choose to continue to be unhappy or seek a more satisfying way of living.

One of the obstacles to change is the act of giving up the past. This requires that one be able to step outside his or her comfort zone. To do something new and different means that you have to stop doing what you did in the past. To illustrate, studies have shown a link between lung cancer and smoking. If smokers are aware of this risk, why do they continue to smoke? Besides possible social pressures and chemical addiction, the more reasons for quitting, the greater the guilt and shame for not quitting earlier. Spiegel (1993) made a valid argument: "If you do something good now, it invariably raises the question of why you did not do it before" (p. 160). Receiving a cancer diagnosis helps remove the barriers to change and to help one make healthier choices.

In addition to changes in life style, other changes may occur in profession or even in medical treatment. For example, medical research and practice are constantly making innovations and discovering new treatments and procedures. However, the medical community can only go so far. Their role is to provide advice, procedures, and medication; but ultimately it is up to the individual to make the necessary decisions that help to create a more favorable outcome. It is still the responsibility of the patient to keep an eye on his or her own health. Peteet (1986) warned us that "besides the well-known behavioral risk factors for cancer such as smoking, diet, exercise, exposure to the sun and toxic substances, there are psychological factors, such as stress, that affect the immune system" (p. 73). Stressors may be the trigger that starts the cancer roller coaster ride. This in turn may be just enough of a push that signals one into action that will lead to a "Time for a change."

The second comment is "Time is our friend." I view this comment as time in a chronological sense. Earlier I discussed how annoying and frustrating waiting can be for a cancer survivor, but now this same chronological time can be a cancer survivor's friend. I believe it is comforting to know, as surely as possible, that there is time left to construct a new life. Realizing that one's life is not yet over allows the preciousness of life to unfold like a new flower. Instead of winding down, one begins to gear up. Fowler (1981) said that time in a chronological sense becomes the way we measure our aging process and has ontological significance. There seems to be a connection between how we respond to our world and how we see our being and the use of our time. It is through the proper use of our time that we can improve our lives. We know that every thought and every action takes time and has the potential to waste time. If you spend too much time on an activity, then you have wasted time and created a potential stressor.

Cancer survivors attempt to use their time on worthwhile activities that are less stressful. Elimination of all stressful activities may not be possible, but there should be an effort to minimize them. Instead of trying to control time, one should use it more effectively. The focus of all energy should be on preventing stress and stressful situations. Even though time is limited, one should string each new day together with the others as if they were forming a string of pearls. This string of days transforms into a life of action.

The third comment, "Time to process," is similar to the second in that it reflects chronological time. Many people who receive a diagnosis of cancer go through a time of grief or mourning. How long this process takes depends upon the individual's diagnosis, treatment plan, resources, and prognosis. The diagnosis is accompanied by losses; some are temporary, while others may be permanent (Harpham, 2003, p. 209). These losses can be physical or mental. Physical losses can include stamina, strength, and even a body part. Mental losses can include loss of control, loss of judgment, and even loss of one's old self. According to Cook and Oltjenbruns (1998), "grief is an experience that is physically, emotionally, and psychologically draining" (p. 99). During this time of grieving, one may mourn the image they have of themselves as a healthy person. In addition, thoughts may turn to the uncertainty of the future. How much time does it take to grieve? This is difficult to answer as each person has his or her own timetable. However, cancer has a unique ability to empower people to do things they would not normally feel capable of doing. Cancer can color one's existence and can influence one's view of the world. Ultimately, as time passes without any major complications or recurrences, the darkness of cancer opens to light. Through the grieving process, the perception of cancer can change from being a life-threatening disease to a stressful event in one's past. This updated perception of cancer transforms a person from victim status to survivor status. During this time, one learns how to transform the dreaded big *C* of cancer into the little *c* of cancer survivorship.

Discussion of the third theme, the outcomes of cancer, includes the following comments: (a) "Time to reflect," (b) "How we spend our time," and (c) "It's about time."

I view the first comment as an expression of chronological time. Capturing and understanding the essence of the lived experience requires appropriate reflection (Van Manen, 1990, p. 77). Thinking chronologically or objectively, one uses this time to think about what one has been through and the impact the events of the past few months or years have had. Taking the time to reflect gives one an opportunity to literally sit down and reflect on what the whole experience has meant. This time allows a person to organize his or her thoughts.

One satisfying result from this reflection is the ability for one to see how far he or she has come since diagnosis. In fact, you might be surprised to discover that you really are no longer a "basket case" but rather a person who "has things together." A personal example comes to mind. Sometimes when I am not feeling especially strong or a bit sad, I wear my 1984 analog Hamilton wristwatch. It has a black face with white hands and numerals. The only problem with this watch is that you have to wind it for it to keep accurate time. I had this watch with me during my initial 26 days in the hospital as well as throughout my chemotherapy treatment. Now whenever I wear this watch, I am transported back to a time when I was too weak to wind the stem. Fortunately, I was not shy about asking someone to wind it for me. As a cancer survivor, I have learned that it is perfectly okay to ask for help. It is during these precious moments that I realize how far I have come. I am sure that every cancer survivor has memories and physical reminders of his or her precious moments. Through our reflections, we are capable of reinterpreting who we once were, who we are now, and who we want to be.

Precious moments are just that: precious moments in time. We all have an increased feeling of wanting to make sure that we use our time wisely. For some, turning 40 years of age is as significant a time factor as anything else. We cancer survivors do not wish time away. We do not say, "I wish it was 4:00 o'clock instead of noon." We try to make the best use out of our time. As Shakespeare said in Macbeth, "To-morrow, and to-morrow, and to-morrow, Creeps in this petty pace from day to day, To the last syllable of recorded time, And all our yesterdays have lighted fools, The way to dusty death, Out, out, brief candle!" (Shakespeare, 1971, p. 1133).

That is exactly what happens. Since the candle of life burns swiftly, one should strive to do the things that have meaning and substance. We become more conscious of wanting to use our time wisely since we know consciously or unconsciously that death comes closer every day. Even though one may believe that there is more to this life than this life, it may also be true that this life is the only physical life one may experience.

I view the second comment, "How we spend our time," as an expression of both chronological and phenomenological time. Our world is not always all or nothing, black or white. We often travel between the two extremes and see numerous shades of gray. As one travels from black to white, so does one travel between chronological time and phenomenological time. A person may plan to spend a certain amount of time on an activity, but once immersion in that activity occurs, clock or objective time ceases and phenomenological or subjective time takes over. It seems that fun and enjoyable activities seem to fly by, while boring or anxious activities slow down or drag on for what seems like an eternity. As I think of time suspended, I am reminded of Salvador Dali's surreal images of time, in particular, his 1932 painting *The Persistence of Memory.* This painting contains three limp watch faces with their times stopped at different hours. Each watch face seems to be melting time away. The image conveys the message that time can be stationary or it can drip slowly away like a snowman on a sunny day.

One of the downsides to chronological time is that it never stops. Everyone ages, and everyone eventually dies. Cancer survivors who are active with support groups tend to go to a lot of funerals and memorial services. Even though these services may be sad occasions, there is a positive dimension to attending these services. One can reflect on what a blessing that person was to his or he life as well as a way of reminding one to take care of one's health and not to get too crazy over things. In essence, these experiences become a form of grounding.

The ability to live one day at a time and to reflect on the meaning of days gone by becomes a strategy for managing oneself as well as for structuring one's time. The ability to reflect on past decisions, good or bad, helps when facing an uncertain future. From these decisions, one learns how and where to allocate precious time and energy. In addition, the process of time allocation provides a sense of control over yourself and new situations. Experience becomes our time management friend as we move forward.

The third comment, "It's about time," is an expression of chronological time. These words invoke the message that the time has come for something to happen. It is as if one were waiting for an incident or circumstance to occur. Thus, being a victim of a robbery, being hit by a car, or getting cancer was eventually going to happen. The longer one lives, the greater the likelihood one will experience one or more disruptive moments. For those who have not had one yet, it may be just a matter of time.

When I think about "It's about time" and reflect on our world today, I cannot escape the evil thoughts and acts of terrorists during the past few years. Events on September 11, 2001 and before created enormous devastation and anguish. There was massive destruction of property as well as loss of thousands of lives. The aftermath of those events is still very much alive in the hearts and minds of millions of people throughout the world. In regard to time and its potential and real devastation, I see a parallel between cancer and terrorism.

When one compares the two experiences, a diagnosis of cancer and being a victim of terrorism, the responses from the victims and onlookers are similar. One similarity is the concept of survivor's guilt. Why is it that when two people with similar lives get cancer, the outcomes may be radically different? One survives while the other one dies.

How does the surviving person cope? Why did that person perish and not me? The same is true for a victim of a bombing asking, “Why did I survive?” Is it just a matter of time before something or someone will strike again?

Another similarity is that the disease, like a terrorist act, seems to “come out of the blue.” Upon reflection one asks, “Why wasn’t I paying closer attention?” The devastation to the direct victim and those surrounding becomes immeasurable. Even though the cancer victim receives a direct hit, the shrapnel hits many others.

Cancer, like terrorism, is certainly an unwelcome event. One’s first reaction is how can I rid myself of it? Forget the costs. If you have to alter or remove a body part, go ahead. Anger and frustration fill your head as you try to figure out what you could have done to prevent it. You travel back in time, tracking down every possible scenario looking for clues as if you were a forensic investigator. You begin to question yourself: “Why I was at that place at that time?” How is it that I was stuck in traffic, or that I overslept, thus not make it into the office that day and therefore was saved from the destruction of the World Trade Towers in New York City on September 11? Why did I smoke cigarettes for so long and not live a healthier life style? I do not have the answers but I do know that the trauma lingers in the air for quite a while. The scar may not be visible to others, but you know exactly where it is. Fortunately, it is the kind of thing where you go from being blind—cancer and devastation is all you see—to a point in time where it is now a minor distraction. For each day of survivorship, the distraction becomes less and less. One chooses for it to become less of a distraction. Even though it may be in one’s peripheral vision, one should not be foolish in thinking that it has completely gone away. Time may not actually heal all wounds.

How long does it take to move cancer from the dead center to the side? For some people, it is a matter of months, while for others it takes years. One has to think about how hard one is willing to work at moving it. Does one wear a badge of honor or a badge of failure? For those who are determined to make good out of bad, it is possible to move it to shadows of one's mind.

However, as with thoughts about what building is next to be struck by terrorism, a cancer survivor wonders, when will I be hit again? Do we tear down all the skyscrapers? Does a woman remove her remaining breast to reduce the chances of it ever happening again? How much does a person have to change to live? Is it healthier to tiptoe through life or walk firmly? Perhaps when people say, "It's about time" they got cancer, it is just one more of life's tests coming their way.

If you or someone you love is ill, use this time to assess and reevaluate your own life. Identify those things that strengthen your relationships, and eliminate those that do not. A cancer victim and his or her family have to take a realistic look at the disease and its ramifications. One has to deal with feelings and emotions and place them in their proper perspective. The cancer victim has to take charge of his or her own life, allowing time to process and heal, while trying to enjoy every day. One may not necessarily live longer, but one can certainly live better.

Summary of Reflection on the Themes

The participants expressed a belief that life is difficult and that the future is often uncertain but that having a positive outlook does make a difference. They talked about how important spending time with friends and family were as well as time spent with colleagues. Even though a cancer journey is an individual experience that can occupy much time, how people spend their time can make a difference. For the participants in this study, knowing that people cared and loved them was comforting and helpful. Not only did this caring and love reflect and reinforce their own beliefs; it also affected their philosophy and implementation of education as well as their general philosophy of life.

The findings suggest the need to explore the multiple meanings of time for other higher education teachers who have had cancer. This involves engaging their beliefs about education and life. Directions for research and practice include the need for further attention to their experiences and the meanings they make.

Reflection on the Methodology

In this section I discuss reflections on my experience with the methodology, thoughts about what I would do differently next time, and myself as the research instrument. Qualitative inquiry, according to Glesne (1999), has three dimensions: reading, reflecting, and doing (p. xiii). I found myself doing these three things throughout the research process. As I gathered the lived experiences from my participants, I spent time reading authors and topics they had mentioned and researching new areas for exploration. When I found interesting information, I wrote notes in my journal to include the date, source, and significance. In addition, as I worked with information in the NVivo software, I attached memos (annotations) to the nodes. These memos were a welcome reminder as to what each node represented. Periodically I printed selected transcripts with their coding stripes and explored the connections. These activities were not linear; they were done simultaneously. As I gained experience, my confidence grew, and I became more comfortable with the ambiguity of qualitative research. Now when someone asks me about qualitative research and we discuss the various aspects and outcomes, I am at ease with saying, "It all depends."

Conducting qualitative research requires discipline and organizational skills. The discipline aspect has to do with managing time, following up on leads, and ensuring that I did what I set out to do. It is a lot like driving a car across the country. You have a final destination, a map with directions, a proper vehicle for the journey, and a tentative timetable. As you travel, it is okay to take some of the roads less traveled and venture beyond the slick highways, but you should always have your final destination in the foreground.

I found that good organizational skills are necessary to keep up with the overwhelming amount of information in the form of books, articles, clippings, pamphlets, and audio and videocassettes. I developed a system for the cataloging, storing, and easy retrieval of information gathered. In addition, as I put my fingers on the keyboard, my research questions and conceptual framework were always in constant view. Miles and Huberman (1994) stressed that "Data management is just as – perhaps even more – important for qualitative researchers" (p. 45). The authors asked the question, how does one keep track of it all? Their response is that researchers need to ensure that everything is easy to use, flexible, and is available at different points of time during the project's life. I believe that having a practical system in place from initial information collection through analysis and final reports was critical for my research completion.

One of the aspects I have enjoyed most about qualitative research is the amount of flexibility. Strauss and Corbin (1998) wrote that grounded theory methodology can be treated as a "smorgasbord table from which [the researchers] can choose, reject, and ignore according to their own tastes" (pp. 8-9). The ability to use these techniques and procedures in various ways was a positive methodological consideration. Even though qualitative research is a "messy affair" (Strauss & Corbin, 1998, p. 32) it does not mean that the research is of little importance or not worthy of consideration. Like the cross-country journey, the best plans or routes seldom occur exactly as one expects.

Throughout the information gathering process, I had to monitor how much of myself I was to share with each participant. It was a struggle at times to keep separate the dual roles of a researcher and a person who had cancer just like the participants. I know at times I shared bits of my own cancer journey to foster a shared appreciation of each person's journey. I believe this was helpful to draw out more of each person's experiences as well as to let the participants know I was not just a person trying to get their story. As Ellis and Berger (2002) explained, "Researcher involvement can help subjects feel more comfortable sharing information and close the hierarchical gap . . . thus promoting dialogue rather than interrogation" (p. 851). Cancer is an individual personal experience filled with emotion and compassion. During this dialogue, one is able to get a deeper understanding of both self and others. Through this interactive interview process, you are not only exploring them, but yourself as well. It is through this process of understanding others that we are better able to understand ourselves.

Although all qualitative researchers are involved in varying levels of intimacy with their research, I have found the discussions about the loss or alteration of body parts, changes in physical capabilities, and psychological changes to be highly personal. The result was that I found myself owning much of what I had found. Even though I wanted to remain in the scholarly arena of academic research, it was difficult to keep myself out of the research. As I wrote the initial narratives and later as I explored the themes, I found myself nodding in agreement with what I was writing. I never felt as though I was overstepping my boundaries as a researcher; nor did I think I was negatively affecting my research. Over time, I felt that my personal involvement and my own sensitivity to cancer were a positive influence on the research process.

As I think about my participant recruitment and selection, I believe I made the correct choice in choosing participants I had not known previously. Seidman (1998) warned us that beginning researchers, like running water, tend to look for the easiest path to the goal (p. 34). The problem with taking the easy approach to choosing participants is that it makes for a messy interview. By not knowing any of the participants, I avoided the awkwardness of a participant saying to me, "Well, you know how things are around here." In fact, I wanted the participants to help me understand from their own perspective. By distancing myself from the participant, I was better able to ensure that nothing was taken for granted or assumed. I did not want to have each person's lived experiences tainted or influenced by my own experiences. Even though the recruitment would have been easier and the information gathering faster, I would not have gotten the rich and diverse stories that have become a part of this research.

Since I was entering the participants' space, I wanted to ensure that I was a neutral entity and that nothing we talked about would have any effect on their academic or personal life. I saw my role as a person who would use his interpersonal skills to encourage each person to share his or her information as openly as possible (Gubrium & Holstein, 2002).

If I were to recruit teachers for another study, I would contact the various local cancer societies and request that they place an announcement in their monthly publications. In addition, I would visit local support group meetings and ask the facilitator to distribute information about my study. Finally, I would ask my oncologist if I could display a poster with information about the study in the office lobby. Even though I was able to successfully recruit a diverse group of people, I believe having additional exposure would have shortened the information gathering process.

In terms of additional questions to ask, two came to mind. The first is, "If you had a recurrence or a diagnosis of a different type of cancer, what would be different about your reaction and treatment plan?" Secondly, "If we were able to find students that you taught prior to your diagnosis and treatment, and then the same ones after your treatment, what would they say was different?" I have attempted to get the cancer survivor's perspective but would find it interesting to know if any significant changes were noticeable to students. Of course, answering the second question may be impossible since it would require tracking students during their academic experience. In addition, there might be confidentiality issues. Finally, the likelihood that a student would actually have the same teacher, once pre cancer and then once post cancer, seems unlikely.

Implications from this Study

This study presents implications for cancer survivors and their loved ones, the medical community, and other researchers. The most compelling message is that "We [cancer survivors] are everywhere," and even though cancer is an individual experience, one does not have to go it alone. Today with high-speed access to the Internet, information and resources are available 24 hours a day at the touch of a mouse click. By navigating the Internet, one can locate support groups for gatherings in their area, participate in virtual support groups and chat rooms, learn about new procedures and clinical trials, and read stories about how others have managed their cancer journeys. Reading these stories can illuminate one's life as well as encourage empowerment. The ability to share your cancer experience with someone else may bring comfort to that person. This comfort factor brings out a positive dimension to your illness. It does not make your illness any better, but it does broaden its meaning. The message is not one of isolation but of unity; thus, your own struggles and solutions can be useful to others with similar difficulties.

In terms of the medical community, it becomes clear that they need to treat the whole person and not just the disease. This whole person needs consideration and understanding not just in terms of the physical body but also in terms of psychological and social needs. For many patients, especially women, it is a traumatic and degrading experience to be naked in front of total strangers for treatment. The simple policy of offering a cloth gown over a paper gown allows one to feel less undressed. Patients deserve respect and consideration. It is amazing how, literally overnight, a fully functional individual can be become a thing, another patient number. Hippocrates, the first historical person in medicine, attempted to close the gap between understanding a disease and its treatment. He believed that the essential function of a physician was to avoid any treatment that might interfere with the healing process. Hippocrates told his disciples in Greece that disease is not only suffering but also toil, that is, the fight of the body to restore itself toward normal (Selye, 1978, p. 11).

The medical community has come a long way, and we as a society have made great strides in how we view cancer and those who get the disease. Historically cancer was a disease of shame and something that we kept as a secret. Even when discussing cancer, people would not even mention the word cancer but rather say, "So and so has the C word."

In the medical community, the word *care* has to be restored to its rightful place, into the health care system. A person with cancer needs two things, according to Spiegel (1993): "accurate and effective physical treatment coupled with support in expressing the feelings associated with being ill and dealing with a new life" (p. 273). Hamilton Jordan (2000), a three-time cancer survivor, emphasized that just a few words from a compassionate physician can make a world of difference. Jordan wrote, "His few words made me feel like someone had poured an enormous bucket of confidence all over me" (p. 169). In other words, the medical community requires high technical expertise, but this should not come at the expense of the patient. I believe that one can receive sophisticated medical treatment administered with a compassionate bedside manner. However, for this to occur, the patient and the medical staff need time to listen to one another. Without listening, no one hears a thing.

Recommendations for Further Research

This study was limited to nine higher education teachers located in the southeast who were willing to participate. Therefore, transferring these findings to other higher education teachers who have experienced cancer and their institutions may not be appropriate. Institutions are comprised of people, and the manner in which people are managed varies from institute to institute. Thus, the policies and procedures in force may vary significantly as well as the individual personalities and agendas of the people in those institutions. However, the theory of Cancer Time may be appropriate to apply and explore at educational and professional environments (Bogdan & Biklen, 1998). The researcher used grounded theory methodology to explore the lived experiences. However, there are other qualitative research designs, such as biography, phenomenological study, ethnography, and case study (Creswell, 1998). In addition, one may wish to design a mixed methods approach, combining quantitative and qualitative designs (Creswell, 2003).

Earlier I suggest implementing other recruitment strategies for selection of participants from other public colleges and universities as well as from private colleges and universities. All but one of the participants was from a state college or university. Would the findings be similar if the participants were from private institutions? Another area of research would be to explore teachers from both public and private schools that teach K through 12 grades. Would the experiences and findings be similar or different?

Finally, the theory of Cancer Time could explore other professions by substituting the operative (italicized) words as appropriate. However, future research should keep in mind that there were two important factors in this study: (1) all participants had cancer, and 2) all were higher education teachers. Acknowledging these two factors, another study could be based on the following: "This research will explore the theory that *nurses* who have survived cancer, through that experience, consciously or unconsciously alter their philosophy of *nursing* and its implementation." Another example, "This research will explore the theory that *veterinarians* who have survived cancer, through that experience, consciously or unconsciously alter their philosophy of *medical treatment of* *animals* and its implementation." Finally, this theory could apply to all cancer survivors regardless of profession by stating, "This research will explore the theory that *people* who have survived cancer, through that experience, consciously or unconsciously alter their philosophy of *life* and its implementation."

Advice from the Participants

The following advice was compiled from the responses to my last interview question, "What advice do you have to help others transition back to teaching?" While none of the participants actually stopped teaching all together, each made adjustments to accommodate the inconvenience of cancer. This list is appropriate for those who have cancer or know someone who has the disease.

1. Try not to skip a beat. In other words, keep on living. I am reminded of the words "Full steam ahead!" One needs to deal with the situation by recognizing it for what it is, open it up, move through it, and then learn from it.
2. Be mature. Get as much information as you can, but do not overload yourself. Do not get into the "paralysis from the analysis." Based on your information, map out a strategy, review your strategy, and then make informed decisions. Once you have made decisions, be accountable and live with your decisions, right or wrong.
3. If you feel good, do all you can do. As you are able, participate as fully as you can in activities that enrich your life. The only constraints are the ones you place upon yourself. The phrase, "Mind over matter" may help.
4. Do not feel like you are a burden to others. Remember that people care about you and want you to live well. Ask for help when you need it. Let your colleagues,

friends, and family be a part of your recovery process. Sharing is a part of human nature.

5. Keep everyone informed as appropriate. Do not allow rumors and innuendo to be the communication medium. Be candid and truthful to others and to yourself.
6. Listen to your body. Honor your body. Do what your body says you need to do. If it asks for rest, give it rest. If you cannot make it to a class or meeting, arrange for a substitute or alternate assignment. If your body needs exercise, exercise. Cancer can get us because we are not willing to listen to our bodies. We often attempt to separate our body from our being.
7. Get involved in something that is physically challenging. Start walking, jogging, boxing, yoga, or anything that gives you physical pleasure, but do something. Get a workout friend. Support each other. Stick to it.
8. Get mentally involved in something that takes you away from thinking about yourself as a disease-ridden individual. Remember, much of your disease is in your head. Thoughts such as, "What if it comes back?" "Did they get it all?" "Do I look OK?" are not productive. Your brain loves to work, so let it.

Personal Reflections

When I first thought about this study, I was nine years post diagnosis. I had been active as a counselor with the American Cancer Society's CanSurmount program. The CanSurmount program attempted to match a survivor with a person who was recently diagnosed. The minimum requirements to be a volunteer were that you had to be at least five years post diagnosis, had to have completed counselor training, and be willing to help others. The society attempted to match volunteers with cancer victims by gender, diagnosis, and treatment. As a volunteer, you shared your experiences, provided other resources, and answered non-medical questions as appropriate. During my time as a volunteer, I counseled with five victims. Two of the victims died within six months of my initial contact, and the other three moved out of the metro area. The original CanSurmount program no longer exists, but the American Cancer Society has numerous support programs that are available via their Web site.

Although I was no longer part of this program, I did want to continue to help other victims, so I thought about sharing my own story. On January 20, 1997, I contacted the medical records department at St. Joseph's Hospital and requested copies of my medical records. A week later, I picked them up. When I arrived home that evening, I opened the sealed envelope and pulled out the 100+ pages. These pages covered my 26 days in the hospital, from October 28 through November 16, 1988. I remember reading the first few pages and then stopping. Even though I did not know all of the medical nomenclature, I had read enough to know I was not ready to read more. Trembling with tears, I put the papers back in the envelope and hid it in my closet. The cancer experience was still too fresh, even though it had been more than 10 years since my diagnosis.

The next time I thought about that envelope was four years later. On June 25, 2001, I was in a classroom at Colorado Sate University in Fort Collins. I was there for two reasons. One was to begin a course on Policy Development with Dr. Ann Foster, and the other was to begin to form my dissertation committee. As the class went on, I thought about my topic and wrote the following two sentences inside my textbook: "How has your cancer experience affected your teaching?" and the other was, "How does having cancer affect a teacher's life?" At our first break, I introduced myself to Dr. Foster and said I wanted to talk with her about my research topic. She smiled, and said, "Sure, after class we can go to my office and talk some more." At the end of class, Dr. Foster and I went to her office and we talked about my ideas. She readily showed interest and agreed to be on my committee. I now had my first committee member and was on my dissertation journey.

Even though I have thought about that envelope many times during this research, I did not open it again until October 30, 2004. I can now read a few more pages without becoming overwhelmed with emotion. I am now more than 16 years post diagnosis, but I still become upset when I go through that envelope. A person never forgets that he or she had cancer. I do not know if all cancer survivors have that metaphorical envelope like the one I do, but I believe they all carry reminders of their disease. As I began to refine my research area and questions, what I fundamentally wanted to find out was this; what were in the envelopes of other higher education teachers who have survived cancer?

I spent the months of July through September 2001 researching this topic but did not find any studies about higher education teachers who had survived cancer. I was buoyed by not finding anything. I now had a viable topic coupled with my own motivation. After almost two years of collecting, analyzing, and writing about my information, I have a study that I am proud to share. As I put down my concluding thoughts, I am reminded of the words, "If your dissertation has not changed your life, it has failed you." Not only has my cancer experience changed me; this research has changed me as well. I was fortunate to be invited into the homes and workplaces of other cancer survivors. It may be true that misery loves company, but so does happiness. Cancer survivors are a special group of thankful and happy people. I would like to conclude with one piece of advice: Instead of worrying how to live with the specter of cancer, spend your time learning how to live life. We may not have much control over how long we live, but we do have control over its depth and breadth. None of us can afford to waste our precious time.

What effect did cancer have on me? Even though the answers still emerge, I am learning that each person who enters my life is a special person, a special gift to be cherished and appreciated. I have learned to discard those acquaintances and relationships that are not supportive. I make time to enjoy the things that I enjoy. I have learned to make better choices and I have learned to take better care of myself and the people who surround me. Viktor Frankl (1984) said, "Man does not simply exist but always decides what his existence will be, what he will become in the next moment" (p. 154). The gift of Cancer Time has enriched my relationships, it has deepened my spirituality, it has renewed my enthusiasm for teaching, and it has strengthened my love of life. My oncologist says, "I walk with a purpose." I like that.

I consider myself privileged to have spent time with these wonderful teachers, to be able to share their stories, and to share a piece of me with you. It is my hope that collectively, our experiences can be used in a constructive way to help others as they make their way through their cancer journey. If I had a magical genie that would grant me a few wishes, I would spend one wish so that no one would ever have to go on a cancer journey. With or without the genie, perhaps one day we will get to a place where a person will never have to hear the words, "I am sorry that you have cancer."

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APPENDICES

APPENDIX A

PILOT STUDY

In qualitative research there are several methods for collecting data such as observation, interviewing and artifact collection (Creswell, 2003). For this study, semi-structured interviews were the primary data collection method in order to get to the lived experience of the participant. The instruments used were a personal information form, an interview guide and the researcher, also known as the human instrument. Thus in this situation, a research partnership was developed between the participant and the researcher (Weiss, 1994).

In addition, Seidman (1998) states that "the root of in-depth interviewing is an interest in understanding the experiences of other people and the meaning they make of that experience" (p.3). The participant shared artifacts and documents that had meaning relating to her cancer experience. Documents or artifacts may include photographs, videos, memos, letters, diaries, and memorabilia (Bogdan & Biklen, 1998). Participant artifacts became part of the description, analysis, and interpretation of the pilot study.

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To participate in the research one had to meet the following criteria: 1) have taught in higher education for at least three years prior to their diagnosis; 2) be located in the metro area; 3) be between one and three years post-diagnosis; 4) is teaching in higher education either full or part-time, and 4) be interested in sharing their story. This criterion satisfied the nature and scope of the study as well as showing concern for the participant.

At the outset, there was assurance of confidentiality. Since cancer is such a personal issue, precautions were in place to ensure that no discomfort occurred during data collection. In addition, the participant received information about the American Cancer Society's various support programs.

This study was based on two 90 minute interviews conducted with a female higher education teacher named Micky. She was a 37 year old, white married female who has been teaching English for the past ten years. Micky is currently finishing her doctoral dissertation in the area of English Literature. She was diagnosed with breast cancer a little over a year ago. Her treatment included a lumpectomy, chemotherapy, and radiation. She is currently in remission.

The participant, recruited through a colleague met the requirements and agreed to participate in the study. The required ethical approvals were obtained and the participant was given a consent form that outlined the scope of the study, the requirements for participation as well as permission to tape record the interviews so that the results may be published, including quotes. In addition, a personal information form was given that provided background information about the participant, which included relevant academic background as well as medical history. The participant selected her own pseudonym for the study. The interviews were tape recorded and transcribed verbatim. Copies of the transcripts were given to the participant for review and editing and were subsequently returned to the researcher.

The audio-taped interviews were conducted at her home. Her husband greeted me both times when I arrived but did not sit in on the interviews. The assumption was that he was either outside or in another part of the home. He was not present at any time during the interview nor upon my departure.

During the interviews, Micky was casually dressed in shorts, sneakers and a t-shirt. She did not wear any jewelry except for her medical ID bracelet on her right wrist. Occasionally she would play with her reading glasses or touch her fingers as if she was counting. When she was asked personal questions, she would pause and gaze through the window as if to search for the answers.

During the interviews, Micky was quite animated, energetic, and eager to talk about her experiences. She did not require much probing in order for her to share her experiences. The second interview captured more of the information related to the research topic and conducting a third interview would not have bought new information. When this situation occurs, one has reached saturation.

The audio-taped interviews were transcribed verbatim and the following transcript conventions were used: (2.0) represents a pause of 2 seconds; (laughter) represents laughter or a giggle; and underlined words represent emphasis. An extract of one of the coded interviews is in Appendix B.

Description of Analytical Strategy

This study utilized a qualitative research design using the principles of Grounded Theory. The data was analyzed utilizing the “three concurrent flows” of data reduction, data display, and conclusion as suggested by Miles & Huberman (1994) and Silverman (2000). With this methodology, one does not begin with a theory and then find data to support it. Rather one begins with an area of study, such as cancer, and then allows the relevant information about that area to emerge in the collected data. In addition, field notes in the form of observer comments are developed. As Merriam (1998) states “An important component of field notes is observer commentary; comments can include the researcher’s feelings, reactions, hunches, initial interpretations, and working hypothesis” (p. 106). It is also important that the researcher document their own personal interpretations so that they do not become part of the data (Merriam, 1998).

Explanation of Data Analysis

Data analysis is the comprehensive, systematic process of organizing, arranging and synthesizing data collected in the field in order to gain an understanding from the research (Bogdan & Biklen, 1998; Merriam, 1998). During the interviews and subsequent transcription process, reflection and exploration for meaning was ongoing. As stated previously, a constructivist grounded theory approach for analyzing the data was used which supported the theoretical and conceptual frameworks for the study.

The data were analyzed utilizing the “three concurrent flows” of data reduction, data display, and conclusion as suggested by Silverman (2000). The first step was to read the transcripts and write down key words in the right margin. The transcripts were read again while listening to the recordings. This second reading of the data provided another listening, which was different from the listening during transcription. As the tape played, a key word or phrase was written on individual 3 X 5 index cards. One card would contain only one word or phrase. The index cards contained the following: Change, Closeness, Denial, Disbelief, Distant connections, Facts and figures, Food, Frustration, Gardening, Guilt, Lesser disease, Little victories, Nurturing, Passivity, Priorities, Quality of life, Reality, Regression back to childhood/home, Relationship with mother, Relationships with others, Religion, Research for answers, Rules, Self-image, Shock, Structure, Support, Teaching, Technology, Time and Unfulfilled expectations. This step became the data reduction phase. Note that even though this looks like a linear process (steps 1, 2, and 3), it is actually an interactive-cyclical process (Miles & Huberman, 1994).

The next step involved scotch taping these cards to the wall in semi-logical groups. After all the cards were up, a bird's eye view was taken, and the cards were moved from one group to another as needed. This process was the data display step.

The final step involved developing major headings or categories for the data as shown in bold in Table. Analyzing the data in this format allowed for better visualization of emerging themes, possible connections, and findings.

Table 1 - Preliminary Findings

Organization	**Education**	**Emotions/Feelings**	**Relationships**
Facts and Figures	Nurturing	Lesser disease	Closeness
Priorities	Teaching	Guilt	Support
Religion	Technology	Passivity	With mother
Rules	Gardening	Denial of death	With others
Structure	Change	Shock	Quality of life
		Disbelief	Regression to home
		Reality	Self-image
		Little victories	Distant connections
		Frustration	

Relevant findings based on this study include data that shows: 1) that the Internet and E-mail were valuable in providing current resources as well as a unique form of support; 2) that formal religious practices were not included in her recovery process; and 3) that the her teaching philosophy and methodology had changed due to her cancer experience.

There were several other themes that emerged from the pilot study, but the one that seemed to be most prevalent was of relationships which coincides with the review of the literature about people encountering a life-threatening illness. For the balance of this paper, the discussion will focus on the relationships category.

Relationships

Individuals change over time due to their experiences. Cancer can certainly alter relationships both inside and outside the family. Using extracts from the transcripts, the relationships category was explored in regards to family and friends. Since it was difficult to decide what to include or exclude, only those quotes that specifically speak to the interactions are shown.

In this first example, Micky discusses her mother's experience with cancer and attempts to relate to her own experiences and expectations.

> Yeah, and I don't know why. I mean, you know, but I just thought well my mom just had a little lump, and radiation and she got through it fine and she didn't really have that many side effects…she was just a little tired, you know I figured oh I'll be that lucky. Oh, you know, like mother like daughter kind of thing, you know, I figured it will be the same, it won't be that bad, you know, it won't change my life dramatically, you know, I'll get it through like she did.

Again Micky talks about her family and friends:

> Well I talked to my mom, and then my mom had a couple of friends who had gone through breast cancer that was a little more serious than what she had. So I talked to her and she talked to some of her friends and then a couple of her friends called me and we talked. (2.) I talked to my friend Janet because her sister-in-law had breast cancer, and she was in kind of the last stages of it so I talked to her to get information from her. (3.0) And I talked to my husband about my options, (2.0) you know, and we (2.0) I (2.0) that night after my husband and I, my mom and I talked I, you know, there were a couple of people I wanted to call. I wanted to call my brother, my father and my friend Janet. And the probably was that I was…my

> mom told me that I needed to tell my dad first, and then maybe my dad should tell my brother cause I wasn't…she wasn't sure how my brother would react. The problem was I kept calling my dad and calling my dad and he wasn't home. So I kept telling my mom okay let me…let me call Janet and she said <u>no, no, no</u>, you got to wait to talk to your dad first. I mean, you know, just be fair to him let him know first and then we'll go from there.

In this example, Micky talks about a friend from out of state who has just completed her treatment. This is the idea of being in the same boat with someone else.

> Well I am involved with a friend, who actually lives out of state, who just finished up her breast cancer treatment. And we probably talk to each other…we used to talk to each other once a week, and now that we're both out of treatment we talk to each other about once a month but we write often. She actually lives in my hometown where I grew up, and I just kind of helped her through the process because she didn't know what to expect, you know, for instance, when she…the first time she lost some hair she called me, you know, crying, and we talked about she should do, you know, what the next step should be. You know should she go ahead and shave her whole head or should she at least cut her hair or something like that so I kind of counseled her through that, and, of course, she had lots of questions for me about side effects of chemo, certain drugs, you know, compared notes on anti-nausea medication we're taking and things like that. And we still talk to this day. Now…now we are beyond talking

> about cancer and talking about gardening and our husbands and things like that.

In this example, Micky talks about some new friends that are survivors just liker her. It seems that people feel better, when they can talk with others, who have experienced the same phenomena.

> Yeah I (laughter) have a lot of new friends who are also, you know, who went through cancer…are cancer survivors and that…that's you know it's nice to have somebody else to talk to and it's really nice to have someone to talk to about cancer who can <u>really</u> understand what you're talking about you know.

Not only did Micky have face to face and telephone conversations, she also found the Internet to be another way of establishing and maintaining relationships.

> No I found a lot of support on the Internet…with folks I've met on the Internet. Or like people you know maybe I'd meet somebody at chemo, and then they'd say oh I know someone your age who had breast cancer why don't you get in touch with so and so and then that's what I would do you know …you know friends or friends of the family who would know someone my age who had breast cancer that now…now I have a relationship with.

And

> No (laughter) actually what happened was…I mean one of the people I talk to on the Internet she is actually the mother of one of my old students and we have <u>never</u> met. I don't even think we've talked on the phone; but

> we just you know e-mail back and forth. And then I have another friend like that who's actually a friend of a friend and she lives in Michigan, I haven't met her, we, you know, just send e-mail back and forth. I mean I think we've talked on the phone a couple of times (4.0) and like the mother of a student she was like always one step ahead of me so I could always e-mail her with questions and she would have an answer. Where as the other person I knew that I talked to on the Internet she was going through treatment.

From these extracts, it seems that some relationships grow stronger and tighter over time while other relationships seem to die a slow death. However, according to Holland and Lewis (2000), the divorce rates are no higher among cancer patients as for the healthy population (p. 212). The relationships with friends also changes, as they may not know how or what to say to you; how to handle a change in your appearance; or perhaps thinking about their own death (Life after cancer, 2001). For the sick person, there is an increased dependence upon others, and a sense of loss of control, which eventually affects the balance in the home. However, when the cancer survivor experiences the loss of a significant other either through divorce, conflict, or death, the burden of coping is increased (Holland & Lewis, 2000, p. 212).

Discussion

This paper examined the relationships of a cancer patient with those of family and friends as well as new relationships established via the Internet. Cancer has a way of threatening and upsetting the status quo and that relationships, either physical or virtual, become important in winning the battle against this life-threatening illness. These excerpts from Micky's story can only hint at the highs and lows she felt as she journeyed from diagnosis through recovery. It becomes clear that cancer makes one vulnerable while at the same time can make one stronger. Micky had to contend with both the emotional and psychological aspects as well as the physiological changes imposed by her treatment which challenged her self-identity. As a final note, each person's cancer journey is an individual experience which is closely related to who is with them at the time and what other ongoing events are occurring.

Implications for Future Research

Research should be conducted that would identify what factors determine when an individual is ready to come to terms with their illness and say to themselves, "Yeah, I really am sick." In addition, cancer patients need to communicate their insights as to what works and what does not work to the people providing cancer treatment services, ongoing monitoring and support. In the educational environment, administrators, staff, and fellow teachers need to have an appreciation and understanding of the phenomenon of cancer and how a teacher with cancer, may look the same on the outside, but they are really quite different on the inside.

APPENDIX B

EXTRACT OF CODED TRANSCRIPT DATA

Guilt
Relationship with mother

the first time I ever really saw myself in the mirror with no hair and I just started bawling. You know, it hit me that I was really…I really…I really had had cancer, you know, it was really happening to me, and it wasn't, you know, a nightmare or a dream or some out of (laughter) body experience I mean it was really happening, you know. And she got a little teary-eyed too. You know cause she…I remember her telling me that she was sorry, you know, like…I'm not sure…I said mom don't be sorry it's not like you made me have it, and she said, yeah but, you know, it's probably my genes. And I said, but what, there is nothing you can do about that, you know, and we just kind of checked out my head (laughter) to see…see how bald I was, and I still had this really dark patch in back that it never did come off. I mean I had it until my hair started growing back, you know, it was just weird. But, you know, it's pretty traumatic when it all came out.

INTERVIEWER: It seems like you have a very close relationship with your mother. (1.0) Could you tell me how this losing your hair and all of that…how that has affected the relationship with your mother?

Relationship with mother
Relationship with others
Closeness

RESPONDENT: Well I think it's…it's even closer I mean she and I have always been close. In my family it's just my mom and dad and my brother and I, and we've always been a close knit family. And when I was growing up she always…when something happened…when something happened to me I got myself in trouble or whatever she didn't necessarily take my side but she was always there to at least listen to what I did or got myself into, and a lot of times my dad would, and I mean, he'll even admit this now, he would over react to something I did, you know, like I missed curfew and I'd get grounded for like a month. You know, he'd really come off with this huge punishment for me and then, you know, I'd talk to mom about it and a lot (laughter) of times, and this is probably terrible, she would go back to my dad and talk about the punishment and say, you know, you know, she's only an hour late don't you think a month is a little bit too much? And then she'd come back to me and say well, okay; you're only grounded a week. So, but, you know, you've got to stick with this week, don't pull anything. But she always, you know, always kind of helped me out of sticky situations. So we've always been close. I've always been able to talk to her about situations or how unfair I thought my dad was or whatever. And it's always been like that. I mean I've always been able to talk to her. We always…I mean for as long as I can remember we've always talked to each other at least once a week. You know if we didn't talk to each other once a week it was usually because, you know, one of us was out of town or, you know, it was finals week or you know, she just kind of let me do my thing to get through with it, and then like like today's phone call, you know, as soon as she knew I was finished with whatever I had to do she called to make sure I was doing okay or whatever. But I've always been really close to her. But we got even closer because she spent so much time here. I mean she was here for my biopsy, she was here for my surgery, she was here for five weeks during my chemo, and she basically came in, and my husband and I just let her take over. You know she was the one who helped make sure the house got cleaned or to make sure, you know, meals, got on the table or ran errands because I…I…you know, when she was trying to do something I could be with her but sometimes I couldn't, you know, she wanted to move furniture one time well I couldn't move furniture but I could be there with her to kind of…you know, she made me feel like I was supervising which I really wasn't. And I'd go grocery shopping with her or whatever but she took over, and we kind of let her take over. And she told me after that whole experience that she (1.0) finally understood what our life is really like, what it's like to be a college professor, what it's like between my husband and I in terms of what our marriage is like, you know, what's important to us. (2.0) I mean I think she learned a lot about, both my husband and I that she didn't realize. You know she learned some things about me that…that she didn't know, you know, how alike I am to her, and how alike I am to my father. And how different I am from my brother. You know I don't think she…she probably kind of sensed it, but she'd never seen it, and she was here with us and she saw, you know, how we lived and how different I am from my brother and, you know.

INTERVIEWER: How long was she here? Can you give me a little timeframe from the initial phone … when you got the phone call on that Saturday?

RESPONDENT: She had already been here a week.

INTERVIEWER: And was she here because why?

Relationship with mother
Closeness

RESPONDENT: Well, actually (laughter) that's kind of a weird story. I asked…I actually asked her to come stay with me because my husband was supposed have surgery…back surgery…actually on the day I scheduled my biopsy, and so like a month ahead of that, I had called and asked her to come help me take care of him. And then when I found I out I needed this biopsy I asked the doctor to schedule the biopsy for the day of my husband's surgery so that I felt like, you know, if we're both there at the hospital my mom could kind of hit two birds with one stone dealing with the both of us, you know. So...so she came down on a Friday (1.0) it was the weekend of Labor Day…Labor Day weekend…she came down on that Friday thinking that she was going to be taking care of both us. And by the time we got…she got here I actually went to get her from the airport we had found out that my husband didn't need surgery, that he had pretty much kind of healed himself, and then his surgery was canceled but, you know, she still came and she wanted to stick around for the biopsy. And she decided that she would stay to get the results, you know, because before that she was coming down, kind of indefinitely to help me get my husband situated; but we kind of had an idea when we thought she'd be able to go home. When now things had changed you know, she was going for sure stay for the results of the biopsy, and then depending on how soon I had surgery, you know, she was going to stay for that too. So, she stayed…the first time she came down she was probably here about ten days cause she went to the biopsy with me, she was here that Saturday when I got my results, and then she stayed I think until that Monday or Tuesday after I had seen the surgeon. Cause I really wanted her to go with me and hear what he had to say. So that if he gave me options, you know, I had somebody else sitting there with me who could listen to these options and give me some feedback you know. And it was really great. She stayed because she encouraged me to take a tape recorder with me to the doctor's office, which I would have never thought about doing. I'm not sure why, but I would have never thought about that, you know, but she encouraged me to take a tape recorder and so my husband and my mom and I went to see the doctor and we had this tape recorder. So we went and listened to the options and then, you know, after we came back home we got to listen to the tape again to kind of think all this out, and she stayed until the middle of that week after I had made my decisions cause I think by Wednesday I had to decide what I wanted to do, you know, if I wanted to have a lumpectomy or a mastectomy, and I had to make that decision and let the doctor know cause then we had to schedule the surgery. So, I made my decision and I called him and let him know what I wanted to do and so she decided to go home (1.0) so she left like that Wednesday or that Thursday and came back that next…I think she and my dad came back that next Monday and stayed with me through surgery, and then I think my dad was here…only here four or five days cause there wasn't much he could do really. I mean he kind of entertained me cause I couldn't do anything, but my mom stayed again for another couple of weeks to help take care of me cause it was hard for me to kind of take care of myself cause I couldn't move my right arm so, you know, washing was difficult and I had a hard time sleeping and she kind of nursed me through all that.

Time
Closeness

APPENDIX C

E-MAIL RECRUITMENT NOTE

Dear ___________________________

Would you please send this e-mail to your entire faculty and not selected individuals?

Thank you for your time and interest.

Regards,

Hank Jordan
Stone Mountain, Georgia
E-mail: HHJordan@aol.com
Phone: 770-414-9302

>>>>>>>>>>>>>>>>>>>>>

Hello,

My name is Hank Jordan from Stone Mountain, Georgia and I am a Ph.D. out reach student in the School of Education at Colorado State University, Ft. Collins, Colorado.

I am in the process of recruiting potential participants for my qualitative study titled "Exploring the Meaning of Cancer in the Lives of Higher Education Teachers."

Participants for this research must meet the following five criteria: 1) have taught in higher education for at least three years prior to their diagnosis; 2) be located in the metro Atlanta area; 3) be at least one year post-diagnosis; 4) be teaching in higher education either full or part-time, and 5) be interested in sharing their story.

Please note that all information will remain confidential and not disclosed to anyone. Your name will not appear in this study or in any publication. At any time, you may withdraw from the study. In addition, there are no risks expected due to your participation in this research.

If you agree to participate, I will interview you three separate times, for one to two hours each time. Even though you may not benefit directly from this research, your participation may lead to a deeper understanding of one's return to teaching after cancer diagnosis and treatment.

You may contact me at home at 770-414-9302 or via E-mail at HHJordan@aol.com.
For additional information about my research, please point your browser to:
http://centerforinventorymanagement.org/MyResearchProject.htm

APPENDIX D

LETTER OF INFORMATION

Exploring the meaning of cancer in the lives of higher education teachers

You are invited to participate in a study to help us learn about the personal experiences of higher education teachers who have had cancer and to understand how their individual experiences have affected and continue to affect their teaching. This letter provides an overview of the study.

You will be asked to participate in three separate, tape-recorded interviews. Each interview will take approximately one and a half to two hours each and will include questions about your background, your health, and your professional life. At the beginning of the interview, you will have an opportunity to ask questions. You will also be asked to complete a brief Personal Information Form and to complete the Consent Form. All information will be filed under a code name to ensure confidentiality. A few days after each interview, you will be provided with a transcript where you will be requested to review and clarify any information as necessary.

The researcher may also write down an occasional note. If you choose, you may refuse to answer any question for any reason. Participation in this study is voluntary. You may refuse to participate or withdraw from the study at any time with no consequence to you. The location of the interviews will be your choice, i.e. your home, at an office, a library, or a suitable alternative. The researcher will make every effort to ensure that the interviews are comfortable and private.

There are no known physical or psychological risks to this study. If a two hour interview may fatigue you, additional meeting times can be arranged to minimize your fatigue. If you like, the researcher will provide names and phone numbers of support personnel. The results of this study may be published including quotes from the interviews. All publications will refer to you, the research participant using your code name. At no time will your name be used in this study or in any publication. Any features that may reveal your identity will be altered in any publication to ensure your confidentiality.

Even though you may not benefit directly from this research, your participation will lead to a deeper understanding of one's return to teaching after cancer diagnosis and treatment. The researcher will answer any further questions about the research, now or during the course of the study and can be reached via telephone at 770-414-9302 or e-mail at HHJordan@aol.com.

Henry H. Jordan (Primary Contact)
Ph.D. Candidate
School of Education
Colorado State University
Ft. Collins, CO 80521
(770) 414-9302
HHJordan@aol.com

Dr. Ann Foster (Supervisor)
School of Education
Colorado State University
Ft. Collins, CO 80521
(970) 491-3168
Foster@cahs.colostate.edu

APPENDIX E

CONSENT FORM

COLORADO STATE UNIVERSITY
INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF PROJECT: *Exploring the meaning of cancer in the lives of higher education teachers: Dissertation Research Proposal for a Grounded Theory Study*

NAME OF PRINCIPAL INVESTIGATOR: *Dr. Ann Foster*

NAME OF CO-INVESTIGATOR: *Henry H Jordan III*

CONTACT NAME AND PHONE NUMBER FOR QUESTIONS/PROBLEMS:
Henry H Jordan III, Telephone 770-414-9302

SPONSOR OF PROJECT: *None*

PURPOSE OF THE RESEARCH: *The purpose of this research is to look at the lives of higher education teachers who have had cancer and to understand how their individual experiences have affected and continue to affect their teaching.*

PROCEDURES/METHODS TO BE USED: *You understand that if you choose to participate in this research, you will be interviewed up to three times for one to two hours each time. The interviews will be tape recorded and transcribed at a later date. You understand that the researcher may also write down occasional notes. You understand that the location of the interviews will be at a convenient time and location and that every effort will be made to ensure that the settings are comfortable and private.*

All files and audiotapes will be kept in a secure limited access location. The co-investigator may discuss the interviews and collected data with his adviser and committee members but only code names or numbers will be used.

RISKS INHERENT IN THE PROCEDURES: *No risks are expected due to your participation in this research. It is not possible to identify all potential risks in research procedures, but the researcher(s) have taken reasonable safeguards to minimize any known and potential, but unknown, risks.*

BENEFITS: *You will not benefit directly from this research; however, you understand that your participation will lead to a deeper understanding of one's return to teaching after cancer diagnosis and treatment. You understand that you will be asked to complete a Personal Information Form which will provide background information about you, your teaching, your cancer diagnosis, and your health status.*

Questions about participants' rights may be directed to Celia S. Walker at (970) 491-1563.

Page 1 of 2 Participant's initials _______ Date _______

CONFIDENTIALITY: *You understand that information in this study will not be disclosed to any person. The results of this study may be published, including quotes from the interviews. All publications will refer to the research participants in code names or numbers. At no time will your name be used in this study or in any publication. Any features that may reveal your identity will be altered in any publication to ensure your confidentiality.*

LIABILITY: The Colorado Governmental Immunity Act determines and may limit Colorado State University's legal responsibility if an injury happens because of this study. Claims against the University must be filed within 180 days of the injury.

PARTICIPATION: *You understand that participation is voluntary. You can stop participating without giving any reason, without penalty. You can ask to have all of the information that can be identified as mine returned to you, removed from the research records, or destroyed.*

Your signature acknowledges that you have read the information stated and willingly sign this consent form. Your signature also acknowledges that you have received, on the date signed, a copy of this document containing __2__ pages.

____
Participant name (printed)

______________________________ ________________
Participant signature Date

______________________________ ________________
Witness to signature (project staff) Date

PARENTAL SIGNATURE FOR MINOR

As parent or guardian you authorize ________________________ (print name) to become a participant for the described research. The nature and general purpose of the project have been satisfactorily explained to you by ______________________ and you are satisfied that proper precautions will be observed.

____
Minor's date of birth

____
Parent/Guardian name (printed)

______________________________ ________________
Parent/Guardian signature Date

Page_2_ of _2_ Participant's initials ______ Date ______

APPENDIX F

PERSONAL INFORMATION FORM

Exploring the meaning of cancer in the lives of higher education teachers

Today's date:______________Code name:_____________________________________

Phone number:______________________________ Best time to call:________________

E-mail address:____

Age at time of diagnosis:______________________ Current age:____________________

Current health status:____

Highest degree earned:____

Teaching field:____

Higher education teaching experience (in years):__________________________

Years teaching prior to diagnosis:_______________________________________

Years teaching since diagnosis:____

Spouse's or partner's occupation:_______________________________________

Marital status:____

Religion:____

Other:

APPENDIX G

INTERVIEW GUIDE

Exploring the meaning of cancer in the lives of higher education teachers

In the delivery of the following questions, the researcher will substitute the phrase such as: tell me about, what helped you, and how are you … to coincide with the appropriate situation for each participant.

Thank you for participating in this research. As mentioned in the consent form, the purpose of each interview is to learn about your experiences with cancer and your return to teaching.

1. Tell me about your diagnosis and prognosis.
   Probes: How did you find out?
   Where were you?
   Who was with you?
   Who did you tell first and why?

2. Tell me about your teaching before your cancer.
   Probes: Why did you choose teaching as a career?
   What do you enjoy about teaching?
   What type of teacher are you?

3. What were some significant experiences related to your work during your cancer treatment?
   Probes: Describe any barriers you encountered.
   Tell me about some highlights.
   Tell me about any support group experiences.

4. Tell me about your return to teaching.
   Probes: What was it like in relation to (dimensions): colleagues, students, others?
   Who or what was a major influence on your decision to return to teaching?
   Why did you decide to return to teaching and how do you feel about that decision now?

5. Reflect on your perception of yourself now as a college professor compared to before your diagnosis.
   Probes: What things are you doing differently?
   How has your experience affected your philosophy towards education?
   How do you view your work now?
   Describe your relationships and involvement.
   What advice do you have to help others transition back to teaching?

APPENDIX H

THANK YOU LETTER FOR PARTICIPATING

Colorado
State
University
Knowledge to Go Places

School of Education
Fort Collins, Colorado 80523-1588

Date _____________

Dear ______________________________

Thank you for your interest in my dissertation research on the experiences of higher education teachers who have been diagnosed and treated for cancer. I value the unique contribution that you can make to my study and look forward to your possible participation. The purpose of this letter is to reiterate some of the things we have already covered.

This study will use qualitative methods whereby I am seeking comprehensive descriptions of your experiences. Through our discussions, I hope to better understand how cancer has affected your teaching philosophy and its implementation.

As a co-researcher, I want you to share your stories, your thoughts, your events, your feelings and behaviors and the people connected with your experience.

I want to thank you for your commitment of time and energy to this study. If you have any questions or concerns please give me a call at (770) 414-9302 or e-mail me at HHJordan@aol.com.

Warm regards,

Henry H. Jordan III

APPENDIX I

THANK YOU LETTER TO NON-PARTICIPANTS

Colorado State University
Knowledge to Go Places

School of Education
Fort Collins, Colorado 80523-1588

Date _____________

Dear ________________________________

Thank you for your interest in my dissertation research on the experiences of higher education teachers who have been diagnosed and treated for cancer. I value the unique contribution that you can make to my study, however at this time I have enough participants.

I want to thank you for taking the time to contact me and your willingness to participate. Should I need additional participants I will contact you for your possible participation. If you have any questions or concerns please give me a call at (770) 414-9302 or e-mail me at HHJordan@aol.com.

Warm regards,

Henry H. Jordan III

APPENDIX J

FREE NODES

1. A good doctor
2. A good friend
3. Anger
4. Avoiding the truth
5. Blame the victim
6. Cancer
7. Cancer as a animal
8. Cancer as a gift
9. Cancer discovery
10. Changed my life
11. Could be anything
12. Dealing with it was a problem
13. Discover who you are within
14. Disregard for the patient
15. Doctor ego
16. Doubts about telling
17. Everything impacts everything
18. Everything was fine
19. Family history
20. Feeling comfortable
21. Getting the truth
22. Going it alone
23. Great learning experience
24. Grief
25. Heavy things
26. Humor
27. It is suspicious
28. Joy of life
29. Learning my lesson
30. Letting go
31. Living life
32. Losing a loved one
33. Low regard for the medical staff
34. Alternative/complimentary healthcare
35. Making decisions
36. Mammogram
37. Maturity
38. Medical frustration
39. My way out
40. Negative impacts
41. Never considered it anything
42. New perspective
43. No evidence of disease
44. Not getting information

45. Obligations too much
46. Positive impacts
47. Priorities
48. Reality
49. Respect for the patient
50. Rewriting your memory
51. Ripe environment
52. Stressful situations
53. Sun shining
54. Survivors
55. Teaching
56. Teaching post
57. Teaching pre
58. Terrorism
59. Time to move on
60. Trying to get healthy again
61. Use of technology
62. Viewing things
63. Wholeness
64. Working with women
65. Worse things

APPENDIX K

THEMES WITH NODES

The Nature of Cancer

1. Cancer
2. Cancer as a animal
3. Could be anything
4. Family history
5. Obligations too much
6. Stressful situations

Dealing with Cancer

7. Anger
8. Avoiding the truth
9. Blame the victim
10. Doubts about telling
11. Feeling comfortable
12. Going it alone
13. Heavy things
14. Humor
15. Making decisions
16. Maturity
17. Never considered it anything
18. Time to move on
19. Trying to get healthy again
20. Use of technology

The Outcomes of Cancer

21. Changed my life
22. Losing a loved one
23. My way out
24. No evidence of disease
25. Positive impact