Citation: Shaha, M. (2003). The omnipresence of cancer. (Unpublished Doctoral thesis, City, University of London)

Die Omnipräsenz von Krebs.

The Omnipresence of Cancer.

Author:

Maya Shaha

Schwirrenmattweg 12 C

CH-5034 Suhr

Switzerland

In completion of the Doctor of Philosophy in Nursing Science at City University, St Bartholomew School of Nursing and Midwifery, London EC1A 7QN, UK.

August 2003.

First supervisor:

Professor Carol Lynn Cox
City University
St Bartholomew School of Nursing and Midwifery
Department of Adult Nursing
20 Bartholomew Close
London EC1A 7QN
United Kingdom

Second Supervisor:

Professor Alfons Grieder
City University
School of Social Sciences
Department of Philosophy
Northamptom Square
London EC1V 0HB
United Kingdom

In memoriam patris mei et pro matre mea.

I dedicate this doctoral work to my parents and my patients – to those who have died and those living with cancer.

Table of contents

Table of Illustrations

Acknowledgements

My thesis would never have been undertaken, written or submitted without the continuing, loving and generous understanding of my family. I thank them from the bottom of my heart for all their creative, critical and never-wavering support.

Special thanks and great appreciation go to Professor Carol L. Cox and Professor Alfons Grieder who have been willing to read, reread, and comment at length on my work. Their support, professionally and spiritually, has kept me going and has been one of the major driving forces in completing my thesis.

I would like to extend special appreciation to Doctor Verena Tschudin. Early on in my studies for a Masters' degree Doctor Tschudin began to support me. She has always been willing to provide generous editorial advice on my written work. Thanks to her, my written English has achieved the level it is now. For the doctoral thesis she was always prepared to look at my written work and managed to read through it in record time. Her perspective has helped me view my work from the reader's perspective.

Throughout data collection and analysis, my panel of experts was always willing to comment at length and in detail. My sincere gratitude goes to them for their support of the study and writing of the thesis.

However, without the professional support and friendship of Doctor Silvia Käppeli I would never have started my academic career at all. Throughout my studies she has been present, willingly providing good advice and emotional support.

Thanks go to all my friends wherever they are, as they never failed to comment, motivate or critique me when I needed it most. In particular the final year of writing up has been a revelation in terms of friendship. Last, but by no means least I wish to express my profound gratefulness to the patients, those who have died and those living, who have contributed verbally and by their generosity to the creation of this doctoral work. Without their wholehearted contributions, the poignancy of their experiences could not have been illustrated.

"I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.”

This thesis was originally written in German and translated into English. Heidegger's writings have been translated from original works written in German. The research subjects' narrative has also been translated from their original spoken language. Therefore the structure of narrative in some sections of the text may appear convoluted or include short phrases in German. This approach has been necessary as there is no satisfactory equivalent in the English language. There are also some sections in the Results and Discussion chapters that appear repetitious. This approach has been necessary in order to demonstrate the relationships of constructs in *The Omnipresence of Cancer*.

Abstract

The incidence of colorectal cancer has increased over the past few decades. Reasons for the increase have been associated with malnutrition (Almendingen et al., 2002; Bain et al., 2002). A need was identified to explore the experience of having received a diagnosis of colorectal cancer and what this means to the person concerned. An empirical phenomenological study was undertaken grounded in Heidegger's Ontology of Dasein as presented in his seminal work 'Being and Time' (1993a; 1996) to investigate *The Da-sein of Colorectal Cancer*. Seven patients diagnosed with colorectal cancer were interviewed over a time-span of thirteen months. The patients were recruited from three hospitals in the German speaking part of Switzerland. At the end of data collection patients specifically pointed out the benefit of having had the opportunity to participate in the interviews. They said the interviews provided them with an opportunity to talk about their illness openly and engage in catharsis.

Data analysis employing Colaizzi's eight step process as cited by Haase (1987: 66-67) elicited one core category - *The Omnipresence of Cancer* - and two sub-categories, *Toward Authentic Dasein* and *Mapping Out The Future*. Each of the sub-categories comprised three constructs that were identified as Uncertainty, Transitoriness and Locus of Control. *Toward Authentic Dasein* represents the Fear and Anxiety (Heidegger, 1993a: 140ff; 1993a: 184ff; 1996: 179ff; 1996: 228ff) patients experienced. *Mapping Out The Future* represents the Existential Understanding (Heidegger, 1993a: 143ff; 1996: 183ff) of Dasein. By associating these findings from the study with Heidegger's Ontology of Dasein (1993a; 1996) *The Omnipresence of Cancer*, a new theory, emerged. *The Omnipresence of Cancer* is a descriptive-explanatory, middle-range theory due to its close association with Heidegger's Ontology of Dasein (1993a; 1996). It provides a perspective on the experience of having received a diagnosis of cancer and what this means for the person concerned.

Receiving a diagnosis of cancer is threatening and provokes deep Fear and Anxiety. Patients experience Uncertainty from the onset of symptoms throughout treatment that extends beyond the conclusion of the treatments. By being given a diagnosis of cancer, patients are confronted with their mortality. They consider their potential demise. In doing so, some choose to move *Toward* a more *Authentic Dasein.*

Coping with the gravity of the illness involves patients' Locus of Control. Initially, patients delegate control to healthcare professionals as a coping strategy. Gradually patients rebell against the delegation of control and work toward regaining it. Moving from an external Locus of Control toward an internal Locus of Control is key in *Mapping Out The Future.* Initial Uncertainty is partly resolved, but new worries arise. In order to successfully manage the return to a familiar routine, patients develop a variety coping strategies in their awareness of the Transitory nature of life. Patients want to return to normality. Therefore, gaining an internal Locus of Control becomes crucial. They realise that cancer is a lifelong disease that stays with them as long as they live. Whenever individuals who have once been diagnosed with cancer are confronted with another health problem, the thought of cancer - whether justified or not - is at the forefront of their minds. Patients consider themselves belonging to an illness group. Cancer is Omnipresent.

"The feeling of being healthy is wonderful. It is great. It is super. After the diagnosis it isn't quite the same anymore. That is clear." (S6)

The Omnipresence of Cancer

A Patient's Diary

Day 1

Oh Gott, the vomiting won't stop. My insides are spilling out of my mouth. The taste is foul and this Furcht und Angst are all consuming. It is unglaublich! The vomiting won't stop... won't stop. Oh Gott, help me... help me. Warum ich? Warum ich?

Day 5

It has been there, growing silently. I've known it. They say they don't know if they have gotten it all. So I wait and wait. There is so much waiting and loneliness. The uncertainty is driving me mad! Darmkrebs they say... its Darmkrebs. The thoughts won't go away... I don't know what to do anymore. There is no way out. I'll leave it to them to decide.

Day 26

I'm dying... Yes it is probably so. I've seen my face. I can't look at it any more. The lines... I've lost my hair. I am no longer the same. The ugly growth that they cut from me is on the outside now. It shows in my eyes, my skin and the bag on my belly... it is foul... foul. It is the Chemotherapie und Darmkrebs... they are killing me!

Day 30

Darmkrebs, oh Gott. Where did it come from? How did I get it? I have always been careful about what I eat. I don't drink and smoke. This is unglaublich! My Furcht und Angst are overwhelming, my emotions are running out of control. My thoughts won't let me rest. Nothing is in my control. Nothing is like it was before. Everything has changed... since the diagnosis. Warum ich? Warum ich?

Day 33

Where is my future? I can't imagine any kind of future... not anymore. What about the trip my husband and I were going to take next year? If I live, will I be able to travel at all? How will it be? Will he want me with this scar on my belly and this bag? How can he stand to look at me now? I can't stand to look at myself. I'm ugly... this thing is hideous! I might be dead in a year. What does it matter now? Warum ich? Warum ich? Why does this thing stay with me? Always there. What have I done wrong?

Day 36

The doctors and nurses are trying to be supportive, despite their lack of time. This hospital is a foul place. It smells of death. It smells like me. I wait. I am alone. Warten und Einsamkeit. I must be dying... the smell of death, the rot and decay, they are all around me. Warten und Einsamkeit. The thoughts of it are in my mind. It is like a broken record, playing over and over again. Everything is so uncertain. There is no escape.

Day 37

The doctors and nurses are talking about me going home. I don't know how this will work out. Everything is so uncertain now. There is the colostomy... Will I ever live a normal life again? My life has been taken over by the Krebs. I can't plan ahead. Others make decisions for me. In some ways, this has been a relief.

Day 60

I have changed. The Chemotherapie is over. I've stopped it. I couldn't stand the treatment on a daily basis with continuous nausea and vomiting. My insides have rotted away... the foul smell. It is always there. I can't keep any nourishment down, however much I try. Even the advice doctors and nurses give does not help. So kann es nicht weitergehen. I know my decision will have grave implications. But, I do not want to be miserable until I die. I want to live fully and enjoy what time I have left. I must take control of what time remains.

Six months later

Since the Chemotherapie was stopped I have felt better. That was six months ago. The two screenings I've had have been good. The screenings are a terrible ordeal. Each time I dread the outcome. Furcht und Angst... It is all consuming. Everything is uncertain. Will I be able to make my own decisions up until the end? Life has changed. Everywhere I look, Krebs is there. Nothing is like it used to be. It is everywhere. It is always with me.

Translation

Oh Gott = Oh God

Furcht und Angst = Fear and Anxiety

Unglaublich = Unbelieveable

Warum ich? = Why me?

Darmkrebs = Colorectal Cancer

Chemotherapie = Chemotherapy

Warten und Einsamkeit = I can't escape my thoughts.

So kann es nicht weitergehen = I cannot go on like this.

Krebs = Cancer

"There is no absolute guarantee that I will not fall ill again. I have been told that I live with the risk that everything may repeat itself." (S5)

1. Introduction

In this introductory chapter, the rationale for the study on which the thesis is based is presented. The research questions are stated, along with the aims of the study. Concluding the chapter is a summary of the study findings leading to *The Omnipresence of Cancer.*

1.1. Rationale For The Study

Cancer has become one of the most important causes of acute and chronic illness in the past few decades (Bain et al., 2002; Benner and Wrubel, 1997; Faller, 1998; Glaus et al., 1997; Meerwein and Bräutigam, 1998; Pestalozzi, 2000; Sahay et al., 2000; Schwarzer, 1997; Walker et al., 1993). There is considerable literature in medicine, nursing, psychology, and other areas, addressing cancer and its origins, its effects on people, and on the family (Faller, 1998; Friedemann, 1992; Glaus et al., 1997; Margulies et al., 1994; Meerwein and Bräutigam, 1998; Radley, 2002; Redmond, 2000; Reinacher-Schick and Schmiegel, 2002; Watson, 1991)[1]. Cancer is one of the most common and wide-spread diseases today. An extensive field of research has evolved to address the complexities of the disease (Benner and Wrubel, 1997; Burton, 1991; Clipp and George, 1992; Flanagan and Holmes, 2000; Haller, 1994; Margulies et al., 1994; Northouse et al., 2000; Norum, 1998; Redmond, 2000). Nevertheless, areas of research that have not been fully explored can be identified

---

[1] For further reference see Almendingen et al. (2002), Käppeli (1998), Nettleton and Gustafsson (2002), Porrett and Daniel (1999), as well as Schulte (2002). See also chapter 3 comprising the literature review.

as gaps in the knowledge base, at least of nursing. The experience of receiving a diagnosis of cancer and meaning of its prognosis is one such area.

Disclosure of a cancer diagnosis and prognosis is the physician's task (Brewin, 1977; Buckman, 1984; McIntosh, 1976; Meerwein and Bräutigam, 1998; Morton, 1996; Ptacek et al., 1999; Slevin et al., 1996). However, nursing practice and the nurse-patient relationship are influenced by it. In particular, the way in which nurses undertake their work and their relationship with the patient is impacted negatively, when nurses have not been present during the disclosure of the diagnosis and prognosis the patient has received. The lack of information impairs an open and trusting relationship between patients and nurses (Burton, 1991; Glaus, 1985; Hofmann, 1995; Kesselring, 1987; Kübler-Ross, 1973; Margulies et al., 1994; Morton, 1996). In the last decade, there have been numerous publications explicating the difficulties that medical professionals have in breaking bad news to cancer patients (Buckman, 1984; Burton, 1991; Campbell, 1994; Faller, 1998; Fallowfield et al., 2002; Glaus et al., 1997; Redmond, 2000; Sahay et al., 2000). Various viewpoints are held about informing patients of their diagnosis and prognosis (Girgis and Sanson-Fisher, 1995; Senn and Glaus, 1998). Some physicians believe that the less information the patients receive, the less distressed they are and the more they will be able to retain sufficient energy to cope with life's changes (McIntosh, 1976; Brewin, 1977). However, there are indications that patients are affected differently. Research implies that some patients want information about the disease. In addition, patients' coping strategies have been underestimated. Perspectives vary about the approach and amount of information that should be given to patients in order to foster the development of effective coping (Bain et al., 2002; Blanchard et al., 1988; Burton, 1991; Fallowfield et al., 2002; Galloway and Graydon, 1996; Grahn, 1993; Haller, 1994; Links and Kramer, 1994; Margulies et al., 1994; Meerwein, 1985b; Miller, 1995; Schwarz, 1985; Slevin, 1987). Ways of solving difficulties associated with breaking bad news and improving the process of conveying the diagnosis to the patient have been described and advocated in literature (Burton, 1991; Morton, 1996; Sahay et al., 2000). However, significant improvements do not seem to have occurred in relation to the process of breaking bad news. It remains a sensitive issue in medicine and nursing.

Intestinal cancer is one of the most frequent causes of fatal illnesses and death (Bain et al., 2002; Courneya and Friedenreich, 1997; Haller, 1994; Markowitz et al., 2002; Norum, 1998; Porrett and Daniel, 1999; Redmond, 2000; Semmens et al., 2000; Shelton, 2002; Wong et al., 2002). Its incidence has increased over the past decade. One of the main types of intestinal cancer is colorectal cancer (Bain et al., 2002; Markowitz et al., 2002; Porrett and Daniel, 1999; Späti and Fust, 1997). Its cause remains largely unknown. Malnutrition is considered to be a major influence on the development of colorectal cancer (Almendingen et al., 2002). However, conclusive evidence has not yet been provided (Eichholzer, 2001; Markowitz et al., 2002). It has been demonstrated that there is a hereditary component to the incidence of colorectal cancer. Some types of colorectal polyposis lead to the development of colorectal cancer (Markowitz et al., 2002; Porrett and Daniel, 1999). However, colorectal cancer is often only discovered by chance. Research is targeted toward tests that diagnose colorectal cancer at an early stage (Hess, 2001; Saddler and Ellis, 1999; Selvachandran et al., 2002). In Switzerland, the Swiss Cancer League has contributed to increasing Swiss people's awareness about colorectal cancer. The Swiss Cancer League advocates eating a healthy diet and engaging in exercise. It publishes leaflets and booklets that promote healthy lifestyles that may combat the development of colorectal cancer.

Quantitative studies in oncology have illuminated the effects of newly developed medications and treatments for people diagnosed with cancer (Berg, 1998; Glaus, 1993; Habr-Gama et al., 1998; Jess et al., 2002; Luna-Perez et al., 2002; Redmond, 2000; Semmens et al., 2000; Shelton, 2002). Several quantitative studies have addressed the quality of life of patients' diagnosed with cancer, as well as perspectives on regaining health (Eakes, 1993; Faller, 1998; Given et al., 2001; Jess et al., 2002; Kagawa-Singer, 1993; Margulies et al., 1994; Ramsey et al., 2000; Schwarz, 1998; Schwarz and Hornburg, 1994; Stiggelbout et al., 1997; Watson, 1991). The studies focus primarily on periods of remission or on the terminal stages of the disease rather than on the experience of receiving a diagnosis and subsequent prognosis (Burton, 1991; Käppeli, 1998; Kesselring, 1987; Kübler-Ross, 1996; Galloway and Graydon, 1996; Haller, 1994; Shelton, 2002). There are qualitative studies elucidating experiences and coping mechanisms of people living with a diagnosis of cancer (Baldegger, 2001; Burton, 1991; Galloway and Graydon, 1996; Käppeli, 1998; Kesselring, 1987). However, patients' experiences of the disclosure of the diagnosis and its impact on their lives have not been investigated thoroughly, despite evidence of its importance for patients' coping processes (Senn and Glaus, 1998). In addition, healthcare practice has drawn on various models of coping - such as the one put forward by Kübler-Ross (1996) - that lack empiric substantiation (Filipp and Aymanns, 1997; Schröder, 1997; Schwarz and Hornburg, 1994). There is also evidence that phase models, which assume a large part in coping theories, do not represent coping processes accurately and therefore are not helpful in supporting patients in their coping (Senn and Glaus, 1998). In Switzerland, Haller (1994) undertook a study employing a grounded theory approach and illustrated the impact of colorectal cancer on patients' lives and their social world. In total 36 patients in various stages of treatment of their disease were interviewed. Analysis exposed the importance of 'being active' (Haller, 1994: 58)[2]. Six different types of disease process were identified. The size of the malignant growth is important in illness management, as it influences treatments and therefore impacts on body changes directly. In addition, coping with changes is important. A single intervention with rapid restoration has less impact on a patient's life than several interventions that imply a lengthy restoration.

---

[2] See section 3.4 in chapter 3.

Although Haller (1994) illustrated in detail the impact of a diagnosis of colorectal cancer on an individual's life, little information was provided about the time-span between diagnosis and initial treatments or the meaning of the illness for the individual. Therefore, a more in-depth investigation into the experience of receiving a diagnosis of colorectal cancer and its meaning to the individual is needed. A phenomenological study was undertaken to illustrate *The Da-sein* (Heidegger, 1993a: 55; 1996: 81) *of Colorectal Cancer*. For Heidegger (1993a: 53; 1996: 78) 'Dasein' denotes the human being[3]; whereas 'Da-sein' or 'Being-there' denotes the Being of Dasein (Heidegger, 1993a: 55; 1996: 81)[4]. Although this study is concerned with the individual diagnosed with colorectal cancer, it aims to describe the Being of the person who has colorectal cancer, hence the selection of *The Da-sein of Colorectal Cancer* as title for this study. Heidegger's philosophy as presented in his seminal work *Being and Time* (Heidegger, 1993a; 1996) was used to inform the study. Heidegger's writings around *Being and Time* and the *Marburg Lectures 1919/20 and 1923/24* (Heidegger, 1993b; 1994) were drawn upon to illustrate and understand Heidegger's philosophy (1993a; 1996)[5]. In *Being and Time* it was Heidegger's declared intention to clarify the question of Being (Heidegger, 1993a: 2ff; 1996: 21ff[6]). His investigation is an ontological-phenomenological one, while *The Da-sein of Colorectal Cancer* is primarily concerned with the ontic. As will be demonstrated in this thesis, Heidegger's Ontology of Dasein (1993a; 1996) has provided the basis for an in-depth understanding of the study's ontic results. By describing *The Da-sein of Colorectal Cancer* and by drawing on Heidegger's philosophy (1993a; 1996) *The Omnipresence of Cancer*, a theory, emerged.

---

[3] Because the author of this thesis is female, the female form will be used throughout the entire text of this thesis. However, it extends to all human beings. With regard to Dasein the neutral term 'it' will be used, in order to respect Heidegger's endeavours to omit value-judgements.

[4] For more details refer to chapter 2.

[5] Heidegger's philosophy was developed at first in his seminal work *Being and Time* (1993a; 1996). However, throughout his life Heidegger was concerned with refining and clarifying issues in his philosophy. Therefore changes in perspectives have occurred over the years. For the purpose of this doctoral work the philosophy as it is presented in *Being and Time* will serve as the core text.

[6] With regard to the referencing for Heidegger's writings, there will be a deviation from the Harvard Referencing System in that the pages are stated as part of the references. This is considered 'de rigoeur' in philosophical referencing.

1.2. Research Questions

The following research questions are addressed in this thesis. The primary question:

- What is the Da-sein of colorectal cancer?

Secondary questions:

- What does it mean to receive a diagnosis of colorectal cancer and its prognosis?
- Does this meaning change over time and if so, how?
- What implications for nursing practice can be derived?

1.3. Study's Aims

The aim of this study is (A) to discern the meaning of the experience of receiving a diagnosis of colorectal cancer and its prognosis and (B) to explicate implications for nursing care of this patient group.

1.4. Research Design

An exploratory, empirical phenomenological approach[7] was undertaken to investigate the experience of receiving a diagnosis and prognosis of colorectal cancer. Seven patients were followed over a 13 month period[8]. Colaizzi's method of data analysis as described by Haase (1987: 66-67) was used to analyse the findings. By

---

[7] Consult section 4.1 in chapter 4.

[8] See Appendix E and section 4.7.2 of chapter 4.

Being-with[9] patients and listening to their stories, *The Omnipresence of Cancer* emerged as the main finding of the research.

1.5. Summary of Main Findings

The study elicited one overarching category that was identified as *The Omnipresence of Cancer*[10]. It encompasses two sub-categories that are: *Toward Authentic Dasein* and *Mapping Out The Future*. As opposed to the general belief put forward by authors such as Kübler-Ross (1996) that patients who have been diagnosed with cancer primarily experience loss and bereavement, subjects involved in the study explicated in this thesis experienced Uncertainty, a realisation of their Transitoriness (the condition of being human and its Transitory existence) and a reconfiguration of their Locus of Control. Receiving a diagnosis of colorectal cancer generated tremendous Uncertainty, due to Fear and Anxiety[11]. In order to cope with having to confront Transitoriness, subjects allowed their Locus of Control to become external. Due to the realisation of the transitory nature of their lives, subjects started to move *Toward* a more *Authentic Dasein*. At the same time, subjects were confronted with the return to everyday life. Initial Uncertainty gradually receded to a manageable level, making room for reconsideration of subjects' Understanding[12]. Confrontation with subjects' Transitoriness provoked changes in outlook and future plans. Within this process Locus of Control was reconfigured and became internal once more. Subjects started *Mapping Out* their *Future* anew[13]. Although Uncertainty, Transitoriness and Locus of Control have been described in the disease process of

---

[9] Confer to section 2.4 in chapter 2.

[10] Also refer to chapter 7.

[11] See section 5.1 in chapter 5.

[12] Compare to section 2.3 in chapter 2.

[13] The Existential Understanding underpins the second sub-category as will be illustrated by the results and discussion chapter 6.

cancer, the interrelationship and the fact that Transitoriness is an important issue already at the disclosure of the diagnosis and prognosis of cancer are new. In addition, the interconnectedness of *Toward Authentic Dasein* and *Mapping Out The Future* as described by the subjects in this study offers a new perspective on the disease process of cancer.

Findings from this study were associated with Heidegger's Ontology of Dasein (1993a; 1996). Thus, *The Omnipresence of Cancer*[14] as a new middle-range theory emerged. The theory is descriptive-explanatory. It emphasises and explicates that cancer is Omnipresent. Patients who have been diagnosed with cancer will never be free of the disease again. A diagnosis of cancer provokes intense Unceraintty, grounded in Fear and Anxiety. At the same time, patients are confronted with the Transitory nature of their lives. They experience a shift from an internal Locus of Control to an external Locus of Control. These experiences bring patients before their Self. Thus, they may consider *Authentic Dasein* and work *Toward* it, if they so wish. Successful management will allocate the diesease a place in the patients' lives. However, screenings to monitor the disease process will always move cancer to the forefront of the patiens' minds. Good news will support successful disease management. Therefore, Uncertainty never completely vanishes again. In addition, the confrontation with the Transitory nature of human existence may impact patients' outlook on life. Future plans are challenged and may need adaptation. Patients work toward their ultimate goal that is to return to everyday life and take up their life-rhythm again.

Platforms, where questions and worries may be addressed and discussed openly with healthcare professionals, support successful disease management. Detailed and clear information is crucial in patients' disease process. Patients develop a variety of coping strategies that are applied according to their needs and the situations in

---

[14] Consult chapter 7 and pages 14ff for the essential structure.

order to successfully manage cancer. Locus of Control plays a central part. From the confirmation of the diagnosis patients undergo a reconfiguration of their Locus of Control. They will delegate their Locus of Control to healthcare professionals in the early stages of their illness. Gradually, patients move to regain their internal Locus of Control. In order to improve care of this particular patient group, healthcare professionals need to understand the interrelationship of Uncertainty, Transitoriness and Locus of Control within *Toward Authentic Dasein* and *Mapping Out The Future*[15]. It is equally important that the interconnectedness of *Toward Authentic Dasein* and *Mapping Out The Future* is recognised and its significance understood, in order to fully comprehend the impact of *The Omnipresence of Cancer*. For nurses the concept of 'true presence', as put forward by Parse (1998: 65) is important in engaging in dialogue with patients diagnosed with cancer. It is further crucial that healthcare professionals understand that cancer is Omnipresent. Only thus will it be possible to comprehend the problems patients with cancer face and appropriate care delivered. Thus, the significance of *The Omnipresence of Cancer* will be understood.

---

[15] See chapters 5 and 6 for more details.

On the one hand, I can’t continue to live without an operation. On the other hand, I can’t continue living as I am now.” (S1)

2. Heidegger's Ontology of Dasein

This research project and thesis uses Heidegger's (1993a; 1996) philosophy as presented in his main treatise *Being and Time*[16] as the philosophical framework for illuminating and understanding *The Da-sein of Colorectal Cancer*[17]. *Being and Time* (Heidegger, 1993a; 1996) contains the ontological-phenomenological account of the human way of being in the world. As such it moves on a level that must be strictly distinguished from that of ontic-empirical investigations such as the one which will be presented later in this work. However, it is one objective of this study to show that the Heideggerian fundamental ontology provides a useful frame of reference for the study of the experience of having been diagnosed with colorectal cancer. Many ontic-empirical findings of this study can be interpreted in terms of Heidegger's approach to human existence, thus enabling insight and an in-depth understanding of many of the phenomena of colorectal cancer. Nevertheless, it is necessary to emphasise that Heidegger's Ontology of Dasein (1993a; 1996) as it is presented in *Being and Time* only offers one distinctive perspective on human existence and it must be recognised that other philosophical perspectives could also relate to the Dasein of colorectal cancer.

Being and Time (more precisely, the published parts of the originally planned work) was meant to prepare the ground for answering the so-called 'question of Being'[18] (Heidegger, 1993a: 5; 1996: 25). According to Heidegger (1993a: 11; 1996: 32), the path to answer the question leads through an analysis of the mode of Being of the entity (the individual being referred to as 'Dasein'[19]) who asks that question. In

---

[16] The philosophical frame of reference draws mainly from Heidegger's seminal work *Being and Time* (1993a; 1996).

[17] See section 1.1 in chapter 1.

[18] Being, where it refers to Dasein and its existence, will be written with capital 'B'.

[19] Also refer to section 1.1 in chapter 1.

other words, in *Being and Time*, Heidegger attempts to give an account of the structures of Dasein's Being. His approach is phenomenological: it is descriptive rather than theoretical-explanatory, and the traditional philosophic and scientific theories about human existence are suspended, as far as this is possible. Being-in-the-world is said to be Dasein's basic condition (Heidegger, 1993a: 11ff; 1996: 42ff), and its essential structures are referred to as Existentials (also called Existentialia[20]). Among these are the following: State-of-mind[21] (section 2.2), Understanding (section 2.3), Being-with-others (section 2.4), Solicitude (section 2.4), the They-Self (section 2.4); all of these will be considered in this chapter. In *Being and Time* Heidegger also deals with Care and Temporality (Heidegger, 1993a: 192; 1993a: 328; 1996: 237; 1996: 376) as embracing structures of Dasein's Being, as well as with finitude of human existence and its Being-towards-death (1993a: 255ff; 1993a: 323ff; 1996: 299ff; 1996: 370ff). For the purpose of the description of the existential aspects of colorectal cancer, it is necessary briefly to outline the Existentials mentioned above, as well as Care and Temporality (section 2.6), Being-towards-death (section 2.7), and the two basic modes of Being, namely Authenticity and Inauthenticity (section 2.5).

2.1. Being-In-The-World

The term 'Being-in-the-world' is a compound expression, indicating Heidegger's holistic approach. Addressing Being-in-the-world Heidegger wrote:

---

[20] Throughout the thesis the term Existential will be written with a capital E. The term Existential is singular and the matching plural is Existentials. There is also the pair Existentiale and Existentialia.

[21] It is necessary to differentiate Heidegger's Existentials from terms of everyday language. Therefore, capital letters will be used to distinguish Heidegger's Existentials.

> "In the interpretation of Dasein, this structure is something 'a priori'; it is not pieced together, but is primordially and constantly a whole." (Heidegger, 1993a: 41; 1996: 65).[22]

Dasein's Being-in-the-world has to be looked at as a whole (Heidegger, 1993a: 53ff; 1996: 78ff). Being-in-the-world is the fundamentally basic condition of Dasein (Heidegger, 1993a: 54; 1996: 79).

Another important point about this fundamental condition is that Dasein and world are inseparable: no Dasein without a world, no world without Dasein. Individuals always find themselves within a world. In turn, world is never without human beings.

> ". . . Dasein itself has a 'Being-in-space' of its own; but this in turn is possible only on the basis of Being-in-the-world in general." (Heidegger, 1993a: 56; 1996: 82).

It is necessary to touch briefly on the aspect of Spatiality. In a sense, the term 'Dasein' already contains a reference to space (Heidegger, 1993a; 1996). 'Da' of Dasein means 'There' (Heidegger, 1993a: 55; 1996: 81)[23]. A human being always occupies space within a world (Mulhall, 1996: 53). According to ordinary understanding, this space includes the location of the human being, as well as her range of action within which she may encounter the world and relate to it (Solomon, 1972: 203). Heidegger, however, speaks of 'Being-in':

> "'Being-in' is thus the formal existential expression for the Being of Dasein, which has Being-in-the-world as its essential state." (Heidegger, 1993a: 54; 1996: 80).

Being-in should not be confused with the everyday spatial meaning of 'being in something' (Heidegger, 1993a: 54; 1996: 79). The Existential Being-in does not simply refer to the spatial location of something, e.g., of flowers in a vase. From Heidegger's perspective Being-in goes beyond the everyday meaning. It is a general condition of Being. The Existential Being-in is instrumental in enabling Dasein to

---

[22] Quotes from Heidegger are drawn from the Macquarrie and Robinson translation of Heidegger's *Being and Time* (1996). In that edition some of the peculiarities of Heidegger's writings such as cursive writing or spaced out writing is copied. For the purpose of this thesis, however, these peculiarities will be left out. The statements will only be provided in normal text writing.

[23] As revealed in section 1.1 of chapter 1, Da-sein is therefore translated as 'Being-there' (Heidegger, 1993a: 55; 1996: 81).

encounter and disclose other entities, be they present-at-hand, ready-to-hand[24] or other Dasein. The terms 'present-at-hand' and 'ready-to-hand' may be predicated of entities, 'presence-at-hand' and 'readiness-to-hand' denoting the corresponding modes of Being and Disclosure to Dasein (Heidegger, 1993a: 68ff; 1996: 96ff).

> "An entity present-at-hand within the world can be touched by another entity only if by its very nature the latter entity has Being-in as its own kind of Being - only if, with its Being-there [Da-sein], something like the world is already revealed to it, so that from out of that world another entity can manifest itself in touching, and thus become accessible in its Being-present-at-hand." (Heidegger, 1993a: 55; 1996: 81).

An entity present-at-hand is disclosed to Dasein as being present. However, presence-at-hand does not refer to its usage. In being present-at-hand, the entity can be encountered and recognised by Dasein. It is available for consideration and analysis (Lettow, 2001: 46). By contrast, readyness-to-hand refers to the kind of Being that is called equipment (Heidegger, 1993a: 69; 1996: 98). Entities ready-to-hand are disclosed to Dasein in their usage. The term 'ready-to-hand' refers to the practical handling of the entity (Biemel, 1996: 47; Luckner, 1997: 41). In the latter mode, Dasein not only encounters an entity, but also recognises its meaning and significance.

For Dasein to be able to have these encounters, entities have to be disclosed to it (Luckner, 1997: 61). According to Heidegger (1993a: 75; 1996: 105) Disclosure means 'to lay open'. The term 'Disclosure' is used to describe how the world becomes accessible to Dasein, but also how Dasein gains access to itself (King, 2001: 30). Through Disclosure, Dasein is able to encounter all entities present-at-hand, ready-to-hand and other Dasein in the world. There are several ways of Disclosure. A lesser mode of Disclosure is called 'Circumspection' (Heidegger, 1993a: 69; 1996: 98). It is linked to the characteristic of Being-in, namely Concern. Being-in-the-world, therefore, relates to the world and other Dasein with Concern. Through Concern, the practical and economical aspects of the world are disclosed to Dasein. In

---

[24] Although present-at-hand and ready-to-hand are terms newly developed by Heidegger, they will not be written with capital letters.

order to encounter entities present-at-hand and to make use of entities ready-to-hand, Dasein discloses the world through Circumspection. Thus, Dasein is able to recognise the meaning and significance of entities present-at-hand and entities ready-to-hand (Heidegger, 1993a: 69; 1996: 98)[25].

> "Dasein is its disclosedness." (Heidegger, 1993a: 133; 1996: 171).

Not only do entities present-at-hand and entities ready-to-hand become accessible to Dasein, but Dasein is also disclosed to other Dasein, and each Dasein to itself (King, 2001: 30; Kunzmann et al., 2001: 209; Mulhall, 1996: 75).

2.2. State-Of-Mind

The term 'State-of-mind' (also called Attunement) denotes an essential structure of Dasein and therefore is an Existential.

> "What we indicate ontologically by the term 'state-of-mind' is ontically the most familiar and everyday sort of thing; our mood, our Being-attuned." (Heidegger, 1993a: 134; 1996: 172).

State-of-mind is Dasein's ontological condition of always being in some mood or other. Dasein is always attuned to the world in one way or another. As an Existential State-of-mind refers to an ontological condition that corresponds - on the ontic-empirical level - with the various moods in which humans find themselves. Through State-of-mind Dasein is disclosed to itself. Therefore, it is possible for Dasein to recognise itself as Dasein distinct from any other entities, be they present-at-hand or ready-to-hand. There are three characteristics of State-of-mind (Heidegger, 1993a: 136-137; 1996: 175-177). The first characteristic is closely connected to 'Thrownness' which is at the same time "a characteristic of Dasein's Being" (Heidegger, 1993a: 135; 1996: 174).

---

[25] Also see Solomon (1972: 206).

> "Ontologically, we thus obtain as the first essential characteristic of states-of-mind that they disclose Dasein in its thrownness, and - proximally and for the most part - in the manner of an evasive turning away." (Heidegger, 1993a: 136; 1996: 175).

Thrownness is closely related to a more fundamental aspect of Dasein, namely the Facticity of Dasein.

> "Whenever Dasein is, it is as a Fact; and the factuality of such a Fact is what we shall call Dasein's "facticity"." (Heidegger, 1993a: 56; 1996: 82).

Dasein is and exists in the world. Thrownness refers to the fact of human existence (King, 2001: 36), of being 'thrown into the world'. The human being is "delivered over to" her existence (Heidegger, 1993a: 135; 1996: 174). Through the first characteristic of State-of-mind, Dasein is disclosed to itself as it exists, as well as where and how it finds itself in the world, and it is brought home to it that, whatever it makes of its own Being is up to itself to decide (Gelven, 1989; 85; King, 2001: 41; Lettow, 2001: 99). The individual's constant Attunement to the world also constitutes her possibility of turning away from the world. While turning away from the world, which can also be perceived as a kind of avoidance, a person's actual existence is disclosed (Luckner, 1997: 63). This leads to the second characteristic:

> "The mood has already disclosed, in every case, Being-in-the-world as a whole, and makes it possible first of all to direct oneself toward something." (Heidegger, 1993a: 137; 1996: 176).

The second characteristic of State-of-mind refers to the fact that moods disclose in every case Dasein's Being-in-the-world as a whole. Awareness is not fragmented, but rather encompasses Dasein in its wholeness. According to Heidegger (1993a: 136-137; 1996: 176) this makes it possible for a person to encounter worldly entities at all. With this second characteristic it is also explained that moods rise within Dasein and "assail" it (Heidegger, 1993a: 136; 1996: 176). Linked to the second characteristic of State-of-mind is the third:

> "Letting something be encountered is primarily circumspective; it is not just sensing something, or staring at it. It implies circumspective concern, and has the character of becoming affected in some way [Betroffenwerdens]; we can see this more precisely from the standpoint of state-of-mind." (Heidegger, 1993a: 137; 1996: 176).

Dasein not only encounters worldly entities, but also lets itself be encountered by them. This disclosure is primarily circumspective[26]. Through moods, which are the ontic manifestations of State-of-mind, Dasein is disclosed to itself as Being-in-the-world. Being constantly attuned and finding itself[27] in some mood or other, also signifies for Dasein that it is dependent on the world where it may encounter entities, be they present-at-hand, ready-to-hand or other Dasein. But it also has the ability to let itself be encountered by other entities present-at-hand, ready-to-hand or other Dasein. Thus, an individual becomes aware of herself and her own existence as the here and now (Gelven, 1989: 84; King, 2001: 55ff).

Fear ["Furcht"][28], as a particular mode of State-of-mind, is used by Heidegger (1993a: 140ff; 1996: 179ff) to illustrate this Existential. Through Fear, the world as it appears to Dasein and entities within the world - be they present-at-hand, ready-to-hand or other Dasein - are disclosed as approaching threats due to their strangeness and unfamiliarity. These threats originate within a specific part of the world that Dasein already considers unnerving and uncanny (Heidegger, 1993a: 140-141; 1996: 179-180). However, Fear is based on the second - and indeed the more important - mode of State-of-mind, which is called 'Anxiety' ["Angst"]. This is the basic State-of-mind and as such denotes that Dasein is first and foremost anxious about itself (1993a: 184; 1996: 228). Anxiety is the ontological condition of Dasein being anxious about its own Being-in-the-world[29]. Where that, which provokes Fear in Dasein can be attributed to a particular entity - be it present-at-hand, ready-to-hand or another Dasein - that, which fosters Anxiety is Dasein itself. It is argued that of which Dasein is fearful can be grasped; whereas that, which invokes Anxiety is much less defined and remains vague (Heidegger, 1993a: 186; 1996: 230-231).

---

[26] Also refer to Luckner (1997: 63).

[27] Here 'to find itself' expresses the fact that humans are always in some mood or other, and they do not pause to consider the mood that they are in.

[28] Fear will be introduced in more detail in section 5.1 in chapter 5.

[29] Anxiety will be introduced in more detail in section 5.1 in chapter 5 of this thesis.

2.3. Understanding

Of equal importance to State-of-mind is the Existential Understanding. It is another fundamental condition of Dasein. Understanding and State-of-mind are tightly interconnected and depend on one another. Both Existentials disclose Dasein in one way or other.

> "As existentialia, states-of-mind and understanding characterize the primordial disclosedness of Being-in-the-world." (Heidegger, 1993a: 148; 1996: 188).

Basically, Understanding may be viewed as another form of Disclosure. The Existential Understanding must be clearly distinguished from the ordinary meaning of 'understanding'. It does not signify grasping or comprehending something by learning about it. In order to describe the Existential Understanding, it is necessary to note the following:

> "Dasein is not something present-at-hand which possesses its competence for something by way of an extra; it is primarily Being-possible." (Heidegger, 1993a: 143; 1996: 183).

The term 'Dasein', therefore, not only refers to actual Being, but is Being-possible. Understanding is the projective disclosure of Dasein's possibilities for Being (Heidegger, 1993a: 144; 1996: 183). Through it, possibilities particular to Dasein are revealed. The projective Disclosure always reveals the whole of Dasein as Being-in-the-world in terms of possibilities for Being (Heidegger, 1993a: 146; 1996: 186).

> "As with existentiality in general, we can, in the first instance, only prepare for the problem of possibility. The phenomenal basis for seeing it all is provided by the understanding as disclosive potentiality-for-Being." (Heidegger, 1993 a: 144; 1996: 183).

One kind of Being-possible for Dasein is its ownmost Potentiality-for-Being. Through Understanding and State-of-mind, the individual's particular and unique possibilities may be laid open to her. It is then possible for the human being to choose from them, thus enabling authentic existence[30]. By contrast, there are also possibilities

---

[30] Authentic existence will be introduced in more detail in section 2.5 of this chapter.

of an average kind that are open for consideration and selection to all human beings in the world. In everyday life, the human being is generally confronted with those average possibilities. Choosing from and confining itself largely to them, is the hallmark of inauthentic existence[31]. According to Heidegger, Dasein is free to choose from the manifold possibilities disclosed (King, 2001: 34-35)[32]. The possibilities disclosed to Dasein through Understanding - be they ownmost or of an average kind - do not necessarily entail Dasein's realisation of these possibilities. Furthermore, Dasein's possibilities do not signify that any possibility can be drawn up and even be selected for realisation. The interconnectedness between State-of-mind and Understanding reveal Dasein's possibilities as dependent on its actual existence (Luckner, 1997: 67).

There are various types of Disclosure, also called 'Sight', which are constituted in Understanding as the fundamental structure; among these are Circumspection and Self-understanding (Heidegger, 1993a: 146; 1996: 186). Transparency, for instance, is a kind of Self-understanding. This may be characterised as the way, in which Dasein makes itself transparent and comprehensible (Heidegger, 1993a: 146; 1996: 186).

2.4. Being-With, Solicitude, And The They

The three Existentials, Being-with, Solicitude and the They are closely related to each other. Each will be briefly explained. Being-with and Dasein-with articulate the ontological condition that Dasein is, and shares the world with, other Dasein.

---

[31] The interrelationship of everyday life and inauthentic existence will be introduced in more detail in section 2.5 of this chapter.

[32] Also consult Solomon (1972: 215ff).

> "The world of Dasein is a with-world [Mitwelt]. Being-in is Being-with Others. Their Being-in-themselves within-the-world is Dasein-with [Mitdasein]." (Heidegger, 1993a: 118; 1996: 155).

Being-with and Dasein-with are existentially constitutive for Dasein's Being-in-the-world. They do not just refer to the fact that there exist many human beings alongside each other (Heidegger, 1993a: 121; 1996: 157), but indicate that other humans are recognised as Dasein, rather than just entities present-at-hand or ready-to-hand. Being-with is Dasein's ontological condition of Being in the everyday (Heidegger, 1993a: 118; 120ff; 1996: 154; 156ff); whereas Dasein-with characterises the ontological structure of other Dasein as encountered in the world[33]. Through Being-with, humans are able to encounter and recognise other humans. It does not signify that Dasein always and constantly needs to be in the company of other Dasein. On the contrary. Due to a privative mode of Being-with, Dasein may also be on its own and alone (King, 2001: 75ff). Through Dasein-with other Dasein in the world are encounterable and recognisable as other Dasein rather than entities present-at-hand or ready-to-hand. Hence, to live as Dasein in a world with other Dasein, both Existentials, namely Being-with and Dasein-with, are essential.

> "But those entities towards which Dasein as Being-with comports itself do not have the kind of Being which belongs to equipment ready-to-hand; they are themselves Dasein. These entities are not objects of concern, but rather of solicitude." (Heidegger, 1993a: 121; 1996: 157).

Dasein as Being-in-the-world considers other entities either present-at-hand or ready-to-hand with Concern[34]. Therefore, entities in the world, be they present-at-hand or ready-to-hand, matter to Dasein. Similarly, Dasein relates to other Dasein with whom it shares the world, through Solicitude. Taken in a more general sense, Solicitude is another type of Care[35]. It characterises the way Dasein relates to other Dasein in the world (Heidegger, 1993a: 121; 1996: 158). Solicitude is grounded in the Existentials Being-with and Dasein-with and comprises several specific forms: among these are 'Being concerned about another', 'Being without one another' or

---

[33] Compare with Biemel (1996: 51ff) and Mulhall (1996: 62ff).

[34] See also section 2.1 in this chapter.

[35] Care is an Existential and will be explained in more detail in section 2.6 of this chapter.

'Passing one another' (Heidegger, 1993a: 121; 1996: 159). These last two modes of Solicitude characterise the 'Being-with-one-another' in everyday life. Dasein's Solicitude towards other Dasein in everyday life is mainly of an average kind (Heidegger, 1993a: 121; 1996: 158).

There are two extreme possibilities to Solicitude, which are called 'to leap in' and 'to leap ahead' (Heidegger, 1993a: 122; 1996: 158). An individual leaps in to take over the concern of another human being, thus intending to unburden her of Care. Leaping ahead, on the contrary, is a way for one human being to support another person in becoming transparent to herself. By leaping ahead, Dasein liberates another Dasein for its ownmost possibilities[36] (Heidegger, 1993a: 122; 158-159). Hence, through Solicitude an individual may support another human being to become aware of her own unique and particular possibilities, thus enabling authentic existence[37].

Within the world, all Dasein as everyday Being-in-the-world are encompassed in a crowd that is the They. The They-Self is the Existential characterising Dasein's average everyday Being-in-the-world (Heidegger, 1993a: 126; 1996: 164)[38].

> "These Others, moreover, are not definite Others. On the contrary, any Other can represent them. What is decisive is just that inconspicuous domination by Others which has already been taken over unawares from Dasein as Being-with. One belongs to the Others oneself and enhances their power. 'The Others' whom one thus designates in order to cover up the fact of one's belonging to them essentially oneself, are those who proximally and for the most part 'are there' in everyday Being-with-one-another. The "who" is not this one, not that one, not oneself [man selbst], not some people [einige], and not the sum of them all. The 'who' is the neuter, the "they" [das Man]." (Heidegger, 1993a: 126; 1996: 164).

The They - or the 'Others' - refers to the way Dasein mostly exists in everyday life. It is 'nobody', hard to grasp, an invisible entity (Heidegger, 1993a: 128; 1996: 166). The term the 'They-Self' does not simply refer to the crowd of all Dasein, although all humans are encompassed by it in everyday life (Heidegger, 1993a: 129-130;

---

[36] In addition, refer to section 2.5 in this chapter.

[37] See also section 2.5 of this chapter.

[38] For further reading see King (2001: 80).

1996: 167-168). The They-Self as an Existential encompasses specific characteristics that are essential to Dasein as everyday Being-in-the-world.

In everyday life Dasein exists submerged in the crowd of the Others and does not stand out. Thus, Dasein understands itself as part of the Others, and the possibilities disclosed to Dasein are basically average, ordinary possibilities, those of the everyday and of everybody, i.e., those of the Others (Heidegger, 1993a: 117; 1996: 153)[39]. As a They-Self Dasein neither is, nor has to be concerned about its ownmost possibilities; it accepts the possibilities of the They-Self as its own (King, 2001: 81). By falling in line with the Others, Dasein is unburdened of its own responsibility and accountability towards itself and Others. The individual can hide behind the anonymity of the They-Self (Mulhall, 1996: 68). As the They is an invisible entity, it voluntarily assumes responsibility (Heidegger, 1993a: 128ff; 1996: 165ff).

2.5. Authentic And Inauthentic Existence

Dasein may be either authentic, or inauthentic, or neither of these modes, but indifferent. Whether an individual lives authentically or inauthentically is her own choice.

> "Dasein exists. Furthermore, Dasein is an entity which in each case I myself am. Mineness belongs to any existent Dasein, and belongs to it as the condition which makes authenticity and inauthenticity possible. In each case Dasein exists in one or the other of these two modes, or else it is modally undifferentiated." (Heidegger, 1993a: 53; 1996: 78).

According to Heidegger, Dasein exists in the most part inauthentically as They-Self, because Dasein first and foremost finds itself in the everyday. Thus, the average and ordinary possibilities disclosed in the They-Self are Dasein's possibilities in the everyday.

---

[39] Compare with Gelven (1989: 73).

> "The Self, however, is proximally and for the most part inauthentic, the they-self." (Heidegger, 1993a: 181; 1996: 225).

Although Dasein is concerned with the issue of Self, its ownmost Potentiality-for-Being is concealed and thus in some way lost to Dasein as They-Self in everyday life (Heidegger, 1993a: 129; 1996: 167).

> "In these modes one's way of Being is that of inauthenticity and failure to stand by one's Self. To be in this way signifies no lessening of Dasein's facticity, just as the "they", as the "nobody", is by no means nothing at all. On the contrary, in this kind of Being, Dasein is an ens realissimum, if by 'Reality' we understand a Being with the character of Dasein." (Heidegger, 1993 a: 128; 1996: 166).

As They-Self, Dasein fails to comprehend and grasp its own Potentiality-for-Being (Biemel, 1996: 44). However, inauthentic existence does offer Dasein direction and answers to life. The They-Self indicates a way life should be lived (King, 2001: 40-42)[40].

> "The Self of everyday Dasein is the they-self, which we distinguish from the authentic Self - that is, from the Self which has been taken hold of in its own way [eigens ergriffenen]. As they-self, the particular Dasein has been dispersed into the "they", and must first find itself." (Heidegger, 1993a: 129; 1996: 167).

By contrast, authentic Dasein recognises and activates its ownmost Potentiality-for-Being. It means that the Dasein has its own Self and stands by it (King, 2001: 41). Authentic Dasein signifies that its ownmost existence is of importance. The possibilities particular and unique to Dasein are disclosed and open for consideration. An individual living authentically is concerned about herself and accepts these possibilities as unique to her. A person's ownmost Potentiality-for-Being may, therefore, be chosen and realised (Biemel, 1996: 44).

Neither Authenticity, nor Inauthenticity denotes a quality. They are both simply modes of Dasein's Being. There is no moral-ethical value judgement implied by either of these expressions. They are ontological terms and are ethically neutral according to Heidegger (Gelven, 1989: 52-53). The two terms are of philosophical service in the quest for the answer to Being (Gelven, 1989: 51ff). They must be under-

---

[40] For further reading see Mulhall (1996: 67ff).

stood in their most original German meaning which is based on the root "eigen"[41]. The German meaning of the root "eigen" may be compared to the meaning of the Latin expression "proprius"[42], as King (2001: 40) explains.

2.6. Care And Temporality

Care and Temporality are both Existentials. As will be shown below, they are interrelated and have an embracing character, linking all the Existentials so far considered together.

Care is an ontological structure underpinning Dasein's Being-in-the-world as a whole (Heidegger, 1993a: 57; 1993a: 131; 1993a: 192; 1996: 84; 1996: 169; 1996: 237). Within Care the Existentials Understanding, State-of-mind, the They and others are linked through its three main structures, which are Existentiality, Thrownness[43] and Fallenness (Heidegger, 1993a: 191; 1996: 235)[44]. Fallenness refers to Dasein's inauthentic existence in everyday life; whereas Existentiality refers to Dasein as Being-possible (King, 2001: 36-38).

> "The formally existential totality of Dasein's ontological structural whole must therefore be grasped in the following structure: the Being of Dasein means ahead-of-itself-Being-already-in-(the-world) as Being-alongside (entities encountered within-the-world). This Being fills in the signification of the term "care" [Sorge], which is used in a purely ontologico-existential manner. From this signification every tendency of Being which one might have in mind ontically, such as worry [Besorgnis] or carefreeness [Sorglosigkeit], is ruled out." (Heidegger, 1993a: 192; 1996: 237).

In the fundamental condition of Dasein which is Being-in-the-world, Care finds expression in Concern. The individual looks at any entities - be they present-at-hand or ready-to-hand - she may encounter within the world with Concern. In everyday

---

[41] "eigen" translates to English as 'own'.

[42] "proprius" is Latin and translates to English as 'own'.

[43] Confer to section 2.2 of this chapter.

[44] Further reading in Biemel (1996: 57-58), King (2001: 36) and Kunzmann et al. (2001: 206).

life, Care is expressed in Solicitude. Care provides the structure of this Concern, as well as Solicitude[45].

> "Because Being-in-the-world is essentially care, Being-alongside the ready-to-hand could be taken in our previous analyses as concern, and Being with the Dasein-with of Others as we encounter it within-the-world could be taken as solicitude." (Heidegger, 1993a: 193; 1996: 237).

The significance and meaning of the Existential Care is not to be confused with the ordinary meaning of 'care'. In everyday language, care means to be interested in a person or an issue and to look after it. There is a value judgement implied with the ordinary meaning of 'care'. Heideggerian Care, by contrast, is devoid of a value judgement. Care as an Existential brings out the fact that its way of Being matters to itself, as well as other entities - be they present-at-hand, ready-to-hand or other Dasein - that are encountered within the world.

Dasein therefore projectively discloses its Being-in-the-world as an entity able to encounter, recognise and relate to other entities within the world be they present-at-hand, ready-to-hand or other Dasein. There is also an awareness and preoccupation with Dasein's Self due to Care (Solomon, 1972: 207)[46]. Due to the embracing quality of Care, Dasein's Existentials are interconnected; thus, enabling Dasein to be and exist in the world as Dasein.

Closely related to Care, and not to be looked at separately, is existential Temporality[47]. It is explained:

> "Temporality makes possible the unity of existence, facticity, and falling, and in this way constitutes primordially the totality of the structure of care." (Heidegger, 1993a: 328; 1996: 376).

The Existential Care, therefore, provides the basis for linking Existentiality, Thrownness and Fallenness; whereas Temporality enables the interconnectedness. Both Existentials, i.e., Care and Temporality, are interrelated and impact one another (King: 2001: 220; Luckner, 1997: 126-127). As an Existential, Temporality does

---

[45] Consult Biemel (1996: 55-61) and King (2001: 97-100).
[46] Compare to section 2.5 of this chapter, as well as to Luckner (1997: 80ff).
[47] Refer also to Gelven (1989: 183) and King (2001: 217ff).

not signify physical time or refer to time-measurements such as the chronological order of seconds, minutes, hours, days, and so on (Heidegger, 1998: 15/15Eff). Everyday as well as physical time can be considered as derivative concepts of the Existential Temporality, which is in fact 'primordial time' (Heidegger, 1993a: 329; 1996: 377).

> "Temporality is the primordial 'outside-of-itself' in and for itself." (Heidegger, 1993a: 329; 1996: 377)

Through Temporality, Dasein 'stands out from itself'. There are three phenomena to Temporality that signify three different ways, in which Dasein stands out from itself. They are subsumed in the term 'Ecstases'.

> "Temporality is essentially ecstatical." (Heidegger, 1993a: 331; 1996: 380).

Through these Ecstases Temporality takes up the three main structures of Care - Existentiality, Thrownness and Fallenness - and thus unites them; thereby becoming the foundation of Care.

The three Ecstases are identified as 'Towards-onself', 'Back-to' and 'Letting-oneself-be-encountered-by' (Heidegger, 1993a: 328; 1996: 377). They represent a threefold 'movement' by Dasein, in the light of which it is possible to consider its comportment. The Ecstasis of 'Towards-oneself' represents Dasein's projection of its possibilities of future existence. The Ecstasis 'Back-to' enables Dasein to make sense of what and how it has already been; whereas Letting-oneself-be-encountered-by represents Dasein addressing the immediate situation at hand (Heidegger, 1993a: 329; 1996: 377). The three Ecstases correspond to the ontic terms of 'past', 'present' and 'future', which are used to describe the succession of time and events in ordinary human life. Among the three Ecstases, however, Towards-oneself which corresponds to the future assumes a focal role, as will be revealed in this thesis, although the three Ecstases are equiprimordial (Heidegger, 1993a: 329; 1996: 378).

> "The primary phenomenon of primordial and authentic temporality is the future." (Heidegger, 1993a: 329; 1996: 378).

Thus, Towards-oneself is Dasein's way of considering its ownmost possibilities and attempt a more authentic existence. With the Ecstasis 'Towards-oneself' a forward movement of Dasein is implied; thereby taking up the ordinary term 'future'. This 'movement' forward does not have an indefinite range. Dasein exists finitely (Heidegger, 1993a: 329; 1996: 378)[48].

2.7. Death And Being-Towards-Death

Dasein is finite. The end of Dasein is death[49]. Dasein is aware of its finitude, even if it does not know at any moment precisely when and how it will come about. Whether to end or not is not within Dasein's choice. Ultimately, death cannot be avoided (Heidegger, 1993a: 250ff; 1996: 293ff)[50].

> "The full existential-ontological conception of death may now be defined as follows: death, as the end of Dasein, is Dasein's ownmost possibility - non-relational, certain and as such indefinite, not to be outstripped. Death is, as Dasein's end, in the Being of this entity towards its end." (Heidegger, 1993a: 258; 1996: 303).

Death constitutes Dasein's unique and ownmost possibility. It is not possible to die the death of another Dasein. Death always belongs to each Dasein as its own[51] (Heidegger, 1993a: 264-265; 1996: 309). Dasein exists towards its own end. Death cannot be avoided. Its own death becomes a certainty for Dasein, while much else about it remains uncertain. The uncertainty and certainty together ultimately constitute Anxiety[52].

> "But the state-of-mind which can hold open the utter and constant threat to itself arising from Dasein's ownmost individualized Being, is anxiety." (Heidegger, 1993a: 265-266; 1996: 310).

---

[48] Also consult King (2001: 36-38) and Kunzmann et al. (2001: 206).

[49] Death is not denoted as an Existential by Heidegger. In addition, the term does not have another meaning than in ordinary language. Hence, 'death' will not be written with a capital D.

[50] For further information compare to Gelven (1989: 139ff), King (2001: 146ff) and Luckner (1997: 100ff).

[51] See King (2001: 150ff).

[52] See also section 2.2 of this chapter and section 5.1 in chapter 5.

Although it is impossible for an individual to experience her own death, the death of another human being makes death a fact and in some ways open to experience (Gelven, 1989: 141)[53].

Dasein's basic ontological condition, namely Care, may therefore also be characterised as Coming-towards-an-end or, more precisely, as Being-towards-death (Heidegger, 1993a: 242; 1996: 286)[54].

> "Care is Being-towards-death." (Heidegger, 1993a: 329; 1996: 378).

Dasein, as long as it is alive, exists in awareness of its end that is death (Heidegger, 1993a: 243; 1996: 287). Being-towards-death discloses the fact that Dasein's existence is finite (Heidegger, 1993a: 245; 1996: 289). There are two ways of Being-towards-death that correspond with the two modes of Being considered above, namely Authenticity and Inauthenticity[55]. Inauthentic Dasein chooses to avoid any overt and direct confrontation with its own end (Gelven, 1989: 140).

> "Even in average everydayness, this ownmost potentiality-for-Being, which is non-relational and not to be outstripped is constantly an issue for Dasein. This is the case when its concern is merely in the mode of an untroubled indifference towards the uttermost possibility of existence." (Heidegger, 1993a: 254-255; 1996: 299).

In everyday life, the certainty of death is recognised by inauthentic Dasein, yet death is not recognised as Dasein's ownmost possibility. Inauthentic Dasein takes refuge in the attitudes and views about death that are characteristic of the They. Death is considered to happen at some point in Dasein's existence; but until that happens, there is no need for Dasein to confront itself with it. Dasein takes refuge in not thinking about its end. Yet, Dasein's utmost, ownmost and unavoidable possibility opens a way towards Authenticity:

> "Death is Dasein's ownmost possibility. Being towards this possibility discloses to Dasein its ownmost potentiality-for-Being, in which its very Being is the issue. Here it can become manifest to Dasein that in this distinctive possibility of its own self, it has been wrenched away from the 'they'. This means that in anticipation any Dasein can have wrenched away from the

---

[53] Compare to Luckner (1997: 104ff).

[54] Consult King (2001: 153ff).

[55] See also section 2.5 of this chapter.

> 'they' already. But when one understands that this is something which Dasein 'can' have done, this only reveals its factical lostness in the everydayness of the they-self." (Heidegger, 1993a: 263; 1996: 307).

As authentic Being, Dasein is free to come to terms with its own death[56]. Thoughts of death, and the Anxiety that goes with it, are no longer avoided. The individual chooses to accept the finitude of his existence. Coming to terms with one's own death does not happen without impact on the human being herself. However, information may be gained, which changes the individual's outlook on life, so that she may choose a more authentic way of life.

2.8. Dasein

In searching for an answer to the question of Being, Heidegger (1993a; 1996) described human beings as complex entities with essential structures that allow them to live in the world and experience it. Human beings as Being-in-the-world may recognise animals and flowers or make use of objects such as a table and chair. Due to Being-with and Dasein-with, the individual is able to encounter, recognise and relate to other humans. State-of-mind and Understanding make recognition and meaningful interpretation for Dasein possible. Dasein's existence is primarily Being-possible. Whether or not the human being chooses to accept and make use of particular possibilities at her disposal is her decision. Projecting possibilities, the individual is oriented towards the future, but draws heavily on the past and present for interpretation and direction.

In the everyday world, the individuality of the human being and her unique and particular Potentiality-for-Being are, on the whole, not properly developed. The possibilities a person projects herself towards are mainly average possibilities; those of

---

[56] Compare also with King (2001: 158ff).

everybody. The individual as inauthentic Dasein is submerged in society, from which she accepts views, attitudes and beliefs.

Human existence is finite; its end, death, is the utmost and unique possibility of the individual. Confrontation with her finitude and death may provoke the human being to question her existence and to attempt a more authentic way of life.

"I couldn’t read what they gave me about cancer. – I looked into the books very quickly, but when I became afraid, I stopped reading.” (S4)

3. Literature Review

Cancer and its manifestations are an area of great interest for many scientific disciplines. Not only are medicine and oncology concerned to discover all there is to know about cancer, but psychology, sociology and nursing are also interested in the subject. Apart from medically oriented studies and treatises, coping models, as well as coping strategies of cancer patients, are explored in the literature.

In this chapter, philosophical aspects of illness and of people coming to terms with a fatal disease will be explored, given that Heidegger's Ontology of Dasein (1993a; 1996)[57] has been selected as a frame of reference for *The Da-sein of Colorectal Cancer*. In order to situate medical, nursing and psychology literature, as well as the thesis, sociological conceptualisations of health and illness will be briefly touched upon. An overview of medical, oncology and nursing literature relevant to this study will follow, with special reference to being diagnosed with cancer, and the illness' effects. A critique will be provided on literature about patients' feelings and reactions in coming to terms with a cancer diagnosis. In addition, coping models and strategies will be addressed, involving a critique of literature associated with being diagnosed with cancer and coping. The purpose of the literature review presented below is to illustrate the gaps in the knowledge base and therefore to provide the rationale for the study *The Da-sein of Colorectal Cancer*. In addition, the literature review in this chapter provides the background for the study findings explicated in the results and discussion chapter of this thesis[58].

---

[57] Refer to chapter 2 for more details.
[58] See chapters 5 and 6 of this thesis.

3.1. The Philosophical Aspects

In this section, aspects of illness will be addressed from a Western philosophical perspective as they are identified to be of importance to the study *The Da-sein of Colorectal Cancer*. Despite the thesis being based on Heidegger's Ontology of Dasein, it is important to take other philosophical writings about illness briefly into consideration. In particular, Jaspers' and Foucault's writings will be addressed in this section.

What is considered as well-being or illness in human life has been of interest to philosophers for centuries. Hippocrates and Aristotle developed their own world-views about bodily functions and the effect of disorder in natural functioning (Helferich, 2000: 14; 47). Paracelsus and others were influential in continuing and expanding the knowledge base (Helferich, 2000: 148). Since the turn of the 19th to the 20th century, the focus on illness and disease increased as human sciences became more established and gained equal position with the natural sciences. In particular, psychology and its development has been a powerful protagonist in this arena. The questions raised in psychology, concerning the effect of psychological disorders, became important to philosophers. Physiological aspects of illnesses and diseases remained in the realm of medical science. Among philosophers, Jaspers and Foucault wrote about the philosophical dimensions of illness and disease. Disease took on a personal aspect for Jaspers as he suffered from a severe respiratory condition that impaired his health at an early age (Hersch, 1990: 8; Saner, 1991: 17). Jaspers indicated that the illness, in his youth, provoked him to consider philosophy (Saner, 1991: 31). Jaspers' illness was considered a life threat. Doctors informed him that he might not live to adulthood. Nevertheless, he reached the age of 86 years. All his life long, Jaspers, who had been trained as a physician, was concerned about managing his illness, adhering to therapies and developing strategies to deal with the disease (Hersch, 1990: 8). Jaspers life-long management of the disease has influenced his philosophy directly. As a philosopher, Jaspers was deeply interested in the psychological aspects of human life and people's potential health problems (Saner, 1991: 31). Important aspects of Jaspers' philosophy are the "Grenzsituationen", i.e., 'boundary situations' (Jaspers, 1991: 879ff). People may always encounter a situation that brings them to the limits of their existence. Struggle ["ich muss kämpfen"][59] (Jaspers, 2001: 18), guilt ["ich verstricke mich unausweichlich in Schuld"][60] (Jaspers, 2001: 18), death ["ich muss sterben"][61] (Jaspers, 2001: 18), hazards ["ich bin dem Zufall unterworfen"][62] (Jaspers, 2001: 18), and suffering ["ich muss leiden"][63] (Jaspers, 2001: 18) were identified as triggers for bringing human beings into 'boundary situations' (Jaspers, 1991: 873ff; 2001: 18)[64]. Being diagnosed with a fatal illness means confronting one's own particular finitude and the possibility of death. Fatal illness therefore may also be considered a trigger for 'boundary situations'. Although it is impossible for human beings to avoid all 'boundary situations', there are two possible ways of dealing with them (Jaspers, 1991: 880ff): the individual may either choose to close her eyes to them, i.e., "der Weg zum Nichts"[65] (Jaspers, 1991: 880), or a person may wish to come to terms with them, i.e., "der Weg zum eigentlichen Sein"[66] (Jaspers, 1991: 880). By choosing the path to Nothingness in dealing with a 'boundary situation', all sense of reality and truth is lost. Chaos breaks out and takes over. People drown in senselessness and utter loss of orientation. Despite this total disorientation, acceptance of Nothingness is possible. Human beings can rely on themselves and their own strengths. Thus, individuals can still live as they wish and fight against everything. They no longer care about their own lives, and do not fear death any longer (Jaspers, 1991: 881). By

---

[59] „Ich muss kämpfen." (Jaspers, 2001:18) is here translated as 'I must fight'.

[60] „Ich verstricke mich unausweichlich in Schuld." (Jaspers, 2001: 18) is here translated as 'I will be unable to avoid becoming guilty'.

[61] „Ich muss sterben." (Jaspers, 2001: 18) is here translated as 'I must die'.

[62] „Ich bin dem Zufall unterworfen." (Jaspers, 2001: 18) is here translated as 'I am subjected to hazards'.

[63] „Ich muss leiden." (Jaspers, 2001: 18) is here translated as 'I must suffer'.

[64] Further reading in Hersch (1990: 28ff), Kaufmann (1989: 161) and Saner (1991: 98-99).

[65] „Der Weg zum Nichts" (Jaspers, 1991: 880) is here translated as 'the path to Nothingness'.

[66] „Der Weg zum eigentlichen Sein" (Jaspers, 1991: 880) is here translated as 'the path to authentic Dasein'.

following the path of Nothingness, individuals remain inauthentic Beings (Saner, 1991: 99).

By contrast, human beings may choose to face up to 'boundary situations'. They decide to work toward authentic Dasein (Jaspers, 1991: 881). Within this second option, a person may again choose either two different possibilities: the first path promises salvation, i.e., "der Weg über die Welt hinaus"[67] (Jaspers, 1991: 881); the second path promises a kind of earthly paradise, i.e., "der Weg in die Welt"[68] (Jaspers, 1991: 881). Whatever path the individual chooses to take, experiencing 'boundary situations' provokes genuine and profound change in her. When following the first path, human beings overcome concerns about themselves and the world. A person is lifted from petty everydayness of human existence and begins to live her life from within a deep and abiding love. Being as such is laid open to experience. There is a distinct resemblance to the concept of salvation in Christianity here (Jaspers, 1991: 881)[69]. By choosing the second option, the individual remains within the world. Again two possibilities offer themselves. The first promises a sense of completion that invokes ideas of paradise, i.e., "Endvollendung"[70] (Jasper, 1991: 881). People live aiming for such a paradisiacal state. This path is not smooth as their ideas are exposed to critique and change over time. Human beings experience occasional collapsing of their ideas. In the second possibility, a person is able to withstand and endure a problematic situation, i.e., "quer zur Welt leben"[71] (Jaspers, 1991: 881).

Experiencing 'boundary situations' brings people to confront their limits. However, 'boundary situations' can be lived through and, whichever option is chosen, individuals benefit. By experiencing 'boundary situations' human beings discover their

---

[67] „Der Weg über die Welt hinaus" (Jaspers, 1991: 881) is here translated as 'the path to beyond the world'.

[68] „Der Weg in die Welt" (Jaspers, 1991: 881) is here translated as 'the path into the world'.

[69] Also consult Helferich (2001: 408), Kaufmann (1989: 213-221 and Kunzmann et al. (2000:201).

[70] „Endvollendung" (Jaspers, 1991: 881) is here translated as 'paradise'.

[71] Verbatim translation to English would be 'living at a right angle to the world'.

own true Being. They work toward their authentic Dasein. Individuals become "Existenz", i.e., 'existence' that is considered life's main goal (Jaspers, 1991: 76; 1991: 879-903). Jaspers' approach to 'boundary situations' appears to reflect his life-long struggle to cope with his illness.[72]

For Foucault (1968: 9ff) the psychological dimensions of human life were also of particular interest. Foucault (1968: 90; 93ff) explored the juxtaposition of human illness and freedom with the influence of the state and the importance of power[73]. The dimension of disturbances and problems of the psyche in relation to individual freedom were very much of interest to Foucault (1968: 31ff). Philosophical dimensions of illness, particularly in relation to psychological disorders, were always evaluated against the background of the potential political freedom of the individual. Foucault (1968: 80) concluded that psychological disorders will never be completely explained, nor will psychology and psychiatry be able to cure diseases of the psyche. A mystery remains, and, therefore, the question of individual freedom cannot be completely resolved. Nevertheless, the human being suffers most dreadfully from illnesses, particularly from psychological disorders (Foucault, 1968: 90).

Apart from mentioning illness or discussing their psychological effects on people, neither philosopher detailed any disease specifically. Their writings on illness suggest, however, that any health problem - be it somatic or psychosomatic - may provoke fundamental changes in people's outlook on their lives. The effect of fatal diseases must therefore be all pervading and all consuming.

---

[72] See Flew (1983: 184-185), Hersch (1990: 28ff), Kaufmann (1989: 177ff) and Saner (1991: 99).
[73] Refer to Helferich (2000: 429ff), Kunzmann et al. (2001: 239) and Taureck (2001: 44ff).

3.2. The Sociological Aspects

Health and illness are not only of concern to the individual, but to all human beings, and therefore society (Dooher and Byrt, 2002; Helman, 2001; Nettleton and Gustafsson, 2002). In sociology, an area of interest that has developed is termed the sociology of health and illness (Petersen and Bunton, 1997; Petersen and Waddell, 1999). Within the field, a lively debate regarding conceptions of health and illness, their interrelatedness and impact on healthcare systems has emerged. Two models have come to the fore. Firstly, there is the biomedical model that emphasises technical aspects of health and illness. Illness is perceived as the absence of health. It is an expression of dysfunction in the human body. Therefore, healthcare professionals; in particular physicians, are perceived to be able to 'cure' the dysfunctioning body. Their skill is generally perceived to be of a technical nature (Nettleton and Gustafsson, 2002; Petersen and Waddell, 1999). The biomedical model, it is argued, does not encompass psychological problems or any other health problems that may not be related to a dysfunctioning body. More importantly, however, the biomedical model does not encourage independence[74]. People who experience health problems also experience a loss of control over some aspects of their lives (Dooher and Byrt, 2002). The power of decision making regarding people's well-being, is allocated to healthcare professionals and doctors in particular[75] (Nettleton and Gustafsson, 2002). The patients' loss of control, and the power attributed to healthcare professionals is perceived to be a major problem in current healthcare services[76] (Dibelius and Arndt, 2003; Dooher and Byrt, 2002). Secondly, in contrast, the social model reflects a critique of the biomedical model. It takes into account that illness may not only mean the absence of health. It is maintained that the mind-body dualism that underlies the biomedical model, is not helpful and may even be dangerous as a

---

[74] For substantiation of this argument see section 5.4 in chapter 5.

[75] Also refer to section 5.4 of chapter 5.

[76] Compare with section 5.4 of chapter 5 and section 6.3 of chapter 6 for substantiation.

number of details in people's conditions may not be interpreted correctly (Nettleton and Gustafsson, 2002). In addition, the social model recognises the various factors that influence health and illness, such as the environment of human beings, their economical situation and culture for example (Dooher and Byrt, 2002; Helman, 2001; Nettleton and Gustafsson, 2002). Due to the interrelationship of social factors and illness and health, it is also argued that perceptions of illness and health are shaped by society. Hence, all human beings have a conceptualisation of illness and health that are influenced by societys' views and attitudes[77] (Helman, 2001). Within this context, according to the social model, people may choose alternative ways of managing their health (such as macrobiotics for the management of cancer) rather than the biomedical model. Notably, however, the biomedical model is still widely used (Dooher and Byrt, 2002), even though the critique of the social model has introduced a wider perspective on conceptions of health and illness that need to be taken into account.

3.3. Informing Patients

Confronting a patient with a diagnosis of cancer has been widely discussed in medical and nursing literature. Two different attitudes have prevailed (Meerwein, 1998). These are either to withhold information from the fatally ill patient for their own good (McIntosh, 1976), or to present them with the truth (Buckman, 1984; Doch, 1995; Hofmann, 1995; Hoy, 1985; Meerwein, 1985a and b). A middle way has also developed that focuses on patients' needs and attempts to provide as much or as little information as they want or need (Brewin, 1977; Buckman, 1989; Campbell, 1994; Schwarz, 1985). Lately, providing truthful and thorough information has be-

---

[77] Confer to sections 5.2, 5.3 of chapter 5, as well as section 6.1 in chapter 6 for substantiation.

come more important. Truthful information is ethically necessary and supports the patients' endeavours to cope with their illness (Buckman, 1989; Henderson, 2000; Hofmann, 1995; Pestalozzi, 2000). The dispute about the amount of information patients need or want regarding their disease, concerns the passivity and dependence of the patient on medical professionals. Therefore, patients maintain an external Locus of Control[78] (Connors et al., 1994; Hallis and Slone, 1999). It is argued that patients voluntarily accept an external Locus of Control and therefore dependence on expert medical advice when they are confronted with a fatal disease (Faller, 1998; Meerwein, 1998). Subsequently, healthcare professionals are expected to empower patients to gain independence by offering support and information about the disease (Glaus et al., 1997; Meerwein and Bräutigam, 1998). The issue of dependence and independence relates to Heidegger's Existential the They[79]. Inauthentic Dasein lives as part of the They in everyday life and accepts the directions and decisions by the They voluntarily and without challenge. Patients' attitudes to expert advice, therefore, tend to reflect Inauthenticity. Healthcare professionals endeavour to empower patients to gain independence and an internal Locus of Control. This is a motivation for patients to consider Authenticity and to choose their unique and personal possibilities[80]. The interrelationship between patients' Locus of Control and Heidegger's Ontology of Dasein (1993a; 1996) has not been addressed in literature. Further insight into human reactions when confronted with a diagnosis of cancer may be gained by drawing on Heidegger's Ontology of Dasein (1993a; 1996), as is demonstrated in this study *The Da-sein of Colorectal Cancer*[81]. Hence, Heidegger's Ontology of Dasein (1993a; 1996) offers a more fruitful approach to human existence.

---

[78] See further section 5.4 of chapter 5.
[79] Refer to section 2.4 in chapter 2.
[80] See section 2.5 in chapter 2.
[81] See results and discussion chapters 5 and 6.

3.4. Patients' Feelings And Reactions

Literature generally describes that patients who are confronted with a diagnosis of cancer experience shock, anxiety and fear for life, as well as depression and dejection (Faller, 1998; Glaus et al, 1997; Henderson, 2000; Margulies et al., 1994; Meerwein and Bräutigam, 1998; Pestalozzi, 2000). These feelings are all pervading and affect patients' lives deeply, as cancer is a life threat. It signifies a confrontation with human mortality. Feelings influence patients' ways of managing the illness situation and are therefore important. The impact of feelings on the individual can be connected to Heidegger's Existential State-of-mind[82]. Moods play a focal role in human existence, colouring individual assessment and evaluation of life. Human beings always experience some moods, even when they feel indifferent. For Heidegger (1993a: 134; 1996: 173) indifference is also an ontic expression of State-of-mind.

Human feelings as reactions to a diagnosis of cancer are tightly connected to the disease process and its phases. Fragmentation of the disease process into phases may be debatable. However, to provide an overview of feelings and reactions occurring after a diagnosis of cancer, fragmentation into phases offers clarification and facilitates an overview. One possibility of staging the disease process is introduced below. At least four different phases in the disease process of cancer can be identified (Meerwein, 1998: 77ff; Schwarz and Hornburg, 1994: 230ff). These are:

1. The prediagnostic phase
2. The initial phase
3. The progressing phase
4. The terminal phase

---

[82] Consult section 2.2 of chapter 2 of this thesis.

According to Meerwein (1985b), patients have different expectations, accompanied by a variety of feelings in each phase, to which doctors and nurses should cater. Patients with abject fears of potentially developing cancer are predominantly found in the prediagnostic phase. These patients may have been confronted with cancer in their family or circle of friends[83]. They may have heard that cancer has a hereditary component that provoked them to consider themselves a potential victim of the disease. Their fears and anxieties are overwhelming, causing them to consult healthcare professionals for advice. For these patients it is important that the medical team respects their fears and anxieties. Examinations and tests need to be carried out thoroughly and carefully so that appropriate information can be given to help combat their fears and anxieties (Meerwein, 1998: 77ff). Ethical issues are discussed regarding preventive cancer screenings (Glaus and Senn, 2001). However, these issues are not of a primary concern regarding *The Da-sein of Colorectal Cancer* and therefore will not be further addressed.

As opposed to the disputes about the amount of information that should be provided to patients[84], Meerwein (1998: 77ff) maintains that patients wish to learn about their diagnosis as soon as possible in the prediagnostic phase. Therefore, medical personnel should attempt to disclose the truth about the patient's condition as soon as definite results are known. However, delays in the provision of information are manifold and may happen in this phase[85]. Meerwein (1998: 78-79) indicates that some delays may be due to society's attitude towards cancer in general and that this may impact healthcare professionals' perspectives on cancer[86]. It is implied that medical personnel may also be afraid and not want to confront fatal diseases (Flanagan and Holmes, 2000; Meerwein, 1998). Nevertheless, delays should be avoided whenever possible (Meerwein, 1998: 78).

---

[83] Compare to section 5.3 of chapter 5.

[84] Refer to section 3.3 in this chapter.

[85] Compare to the results and discussion chapters 5 and 6 in this thesis.

[86] Refer back to section 3.2 in this chapter.

Information about the disease and treatments is paramount in the second phase. Comprehensive and clear information supports positive illness management by the patient (Bain et al., 2002; Blanchard et al., 1988; Fallowfield et al., 2002; Henderson, 2000; Lind et al., 1989; Pestalozzi, 2000; Schwarz, 1985). In the second phase patients build up excessive optimism as a coping strategy that is supported by doctors and nurses (Meerwein, 1998: 79). In general, physicians are able to accept and to comply with patients' wishes for clear and thorough information, thus creating an open atmosphere. Patients coping with the gravity of the disease are supported by an open and truthful atmosphere between patients and healthcare professionals[87] (Bain et al., 2002; Fallowfield et al., 2002).

Only in the third phase of the illness process do fears and anxieties about isolation, separation and loss become important, according to Meerwein (1985b; 1998). Patients no longer have the same high hopes as they did in the second phase. Insecurity is experienced by patients, as well as by doctors and nurses. The communication process may become severely strained. It is most important to maintain an open and constant dialogue between the medical team and patients. Meerwein (1998: 81) further indicates that patients in the third phase become increasingly dependent on physicians and nurses. Patients have thoughts about being abandoned by the medical team. They loose hope and trust, because very little can be done to help (Meerwein, 1998: 82). Despite these difficulties, it is possible that the initial trust in doctors and nurses can be re-established (Meerwein, 1998: 82).

In the diversity of human feelings, hope assumes an important position. Hope expresses the human will to live, whatever the situation in which individuals may find themselves (Bühlmann, 2001: 103; Kylma and Vehvilainen-Julkunen, 1997). With hope, issues of human future and expectations are implied. Individuals project wishes and ideas about their future. Hope refers to people's expectations that

---

[87] For substantiation refer to section 6.3 of chapter 6.

something positive will happen in their future lives. Nevertheless, expectations cannot be equalled with hope as such. Having expectations implies that an issue is counted on to happen. A variable amount of detail may be known about an issue that is expected to happen, therefore predictions - whether accurate or not - are possible. As opposed to hope, expectations include predictive details. Issues that a person hopes for will happen, only allow for speculation. It is quite unclear and uncertain whether they will happen and how they will come about (Holt, 2000).

> "Hope means believing in life that everything will turn out well." (Bühlmann, 2001: 103).

Therefore, hope refers to unspecific wishes whose realisation is questionable until they happen. People having hope implies a profound belief in positive outcomes that may eventually occur. Several sources and contributors to hope have been identified. People need to feel safe within their personal, social and economical environment. Well-being and good health are supportive; individuals should have developed a profound trust in their Dasein[88]. Spirituality and religious beliefs are also perceived to be of high importance (Benzein and Saveman, 1998; Bühlmann, 2001: 108; Elbright and Lyon, 2002; Saleh and Brockopp, 2001). They are sources for motivation and positive beliefs[89].

The last phase of the disease is characterised by non-verbal communication between patients and healthcare professionals. Due to the longstanding relationship between patients, doctors and nurses, communication between them no longer needs words. Both may communicate in silence and still understand each other, according to Meerwein (1998: 83). Through presence and by sustaining moral support, doctors and nurses alleviate some fears and anxieties that patients experience (Parse, 1998)[90].

---

[88] For more information consult section 2.8 of chapter 2.

[89] See section 6.1 in chapter 6 for substantiation.

[90] See section 5.3 of chapter 5, and sections 6.2 and 6.4 of chapter 6.

The fragmentation of the disease process into phases suggests that feelings and reactions only occur in one phase or the other, but never at the same time. However, there is evidence that fears and anxieties are accompanied by uncertainty at the disclosure of the diagnosis of cancer (Black and Hyde, 2002). There is further indication that patients need to have sufficient information about the disease process so as to be able to cope successfully (Galloway and Graydon, 1996; Glaus et al., 2002; Northouse et al., 2000)[91].

The Swiss Cancer League has initiated a project to find out about the potential destructive events in the life of patients with colorectal cancer. Haller (1994; 2000) conducted a study with a group of patients who had been diagnosed with colorectal cancer. In total, 36 patients were recruited via the Swiss Cancer League. All participants were at different stages of their disease process and receiving different treatments. In all, 40 interviews were conducted. Study design and data analysis followed the grounded theory method developed by Glaser and Strauss (Haller, 1994; 2000). Analysis revealed six areas of experience where destruction and restoration are taking place (Haller, 1994: 52ff; 2000: 83ff):

1. The body
2. Being active
3. Cognition/Emotions
4. Social context
5. Material area („materieller Bereich")
6. Changing relationships.

The disease attacks the body. For therapeutic reasons patients have to undergo surgical interventions that change the body. In cases where an ileostomy or colostomy becomes necessary - either temporarily or permanently - the body bears the out-

---

[91] Refer to sections 5.2 and 5.4 of chapter 5 and section 6.2 of chapter 6.

ward signs of its inner destruction[92]. There are visible and invisible scars, enhancing the process of stigmatisation[93]. Bodily changes affect the patient's range of activities. Due to recovery from surgical interventions or other therapeutic treatments that affect patients' well-being, their range of activities may become limited[94]. Patients may be confronted with gradually having to take up their previous routine[95]. In some cases, they may be forced even to change a life-long routine completely. Thoughts about the future are not the same as before the diagnosis of colorectal cancer[96]. Some activities may be no longer possible. The disease also affects social relationships[97]. In most cases, family and friends are drawn into the circle of the disease. Issues about informing and discussing the disease in the family are raised, disclosing problems in communication (Black and Hyde, 2002). Social activities may have to cease or their routine adapted to the new range of abilities. For some patients the illness also involves a financial burden. Healthcare services are delivered at a high price in Switzerland. For some patients the insurance rates and bills are almost impossible to pay and they have to take up assistance from social institutions. They become dependent on social welfare which is considered degrading. Haller (1994; 2000) concluded that the destruction of the body and the social world of the patients due to the disease lie outside the patients' control[98]. Uncertainty regarding the causes of colorectal cancer weighs heavily on them[99]. Haller's (1994; 2000) findings demonstrated the importance of 'being active'. Four basic categories were identified in Haller's research (Haller, 1994: 58; 2000: 87ff):

1. I am able ["ich kann"]
2. I am still able ["ich kann noch"]

---

[92] Compare to section 5.2 of chapter 5.
[93] Refer to section 5.2 of chapter 5.
[94] Confer with section 5.4 of chapter 5.
[95] Also see section 6.3 of chapter 6.
[96] Substantiation is to be found in section 5.3 in chapter 5.
[97] Compare to section 5.3 in chapter 5.
[98] Refer to chapter 7, sections 7.1.3 and 7.1.4.
[99] See section 5.2 in chapter 5.

3. I am able again ["ich kann wieder"]
4. I am newly able to do ["ich kann neu"].

The four categories of 'being active' illustrate the degree of impairment and the patient's attempts to restore her world. Of the four categories the last - I am newly able to do - indicates benefit despite the severe handicaps and barriers the disease imposes on the patient. 'Being active' is interconnected with the concept of restoration in one's life. Patients put their energy into restoration of the social environment and of their world. However, the outcome of such restoration cannot be predicted. It is dependent on the patient herself. Haller (1994: 61ff; 2000: 92ff) stated that restoration and destruction are tightly interconnected and function in reciprocal action. Besides destruction and restoration, based on the four categories of 'being active', suffering is extremely important. Three variations of suffering were identified as being key to patients with colorectal cancer:

- Suffering due to the slow destruction of the body
- Suffering because resources are limited
- Suffering because all resources are used up

From these findings, Haller (1994: 65ff; 2000: 96ff) developed a model with six variations of how colorectal cancer destroys the social world of an individual and how a way is found to re-gain or to modify life accordingly. These are:

1. Single destruction - Rapid restoration.
2. Single destruction - Rapid restoration with colostomy.
3. Single destruction - Delayed restoration.
4. Single destruction or several destructions at short intervals - little or limited restoration of the body, impressive restoration in other areas of interest.

5. Single destruction or several destructions at short intervals - little or limited restoration of the body, hardly any restoration or resources left in other areas of interest.
6. Several destructions at intervals of at least one year - several restorations.

The term 'single destruction' indicates that there had only been one diagnosis of colorectal cancer that was treated. After conclusion of treatments, the patient was able to return very quickly to her habitual way of life. Patients did not have another episode of cancer. Some patients had to contend with a permanent colostomy, because complete removal of the tumour included total rectum amputation. Nevertheless, they recovered quickly and nothing more was found. Delayed restoration occurs after initial treatments were completed. Some patients in Haller's study (1994) experienced a single bout or several bouts of cancer. Due to the disease, their body was severely impacted. Haller's findings (1994; 2000) imply that patients are engaged in an intensive time of restoration. Due to the illness, patients may be forced or guided to explore their physical, emotional, as well as economical resources and use them to discover and open new areas of interest. Haller (1994: 149; 2000: 101) illustrated that patients' efforts at restoration are impressive and extensive. In addition, the various forms of destruction and restoration offer details about the disease process, thus facilitating understanding.

Patients diagnosed with cancer fear social isolation and react to their fears with retreat. Although cancer is discussed openly in society, there are rarely positive statements made about it, thus increasing a person's fears and anxieties (Benner and Wrubel, 1997: 314; Faller, 1998: 13; Käppeli, 1998: 141ff; Meerwein, 1998: 91ff; Meerwein and Stiefel, 1997: 264ff; Redmond, 2000; Schwarz and Hornburg, 1994: 219). Being diagnosed with cancer bears the stigma of impending mortality for people concerned[100] (Black and Hyde, 2002; Flanagan and Holmes, 2000). Stigma in

---

[100] Refer to section 5.3 in chapter 5.

relation to illness signifies lower social esteem (Schulte, 2002). There are diseases that society regards as less deserving of support or even recognition. Cancer is counted among them (Flanagan and Holmes, 2000; Schulte, 2002). Stigmatisation is caused by a variety of issues that altogether serve to justify society's perspective to exclude people because they belong to a specific illness group. One such issue may be a visible disfigurement due to an illness, such as a limp. Although hidden beneath layers of clothing, ileostomies or colostomies are also considered stigmatising. They are identified by unpleasant odour, promoting exclusion and restricting the individual's range of activities[101]. However, stigmatisation does not only refer to externally visible signs, but also includes invisible handicaps associated with diseases like diabetes or cancer (Schulte, 2002)[102]. Thoughts and invisible signs of the illness lead to separation and exclusion from society as much as visible scars or outward signs. People who have been confronted with a disease such as cancer may in some cases such as breast cancer bear visible signs of their illness. Others such as individuals diagnosed with colorectal cancer have an abdominal scar that is in general not visible to society. Therefore, they carry the stigma in their minds.

Living with colorectal cancer, as well as patients' feelings and reactions have been detailed and explained in literature. However, the meaning of the experience of receiving a diagnosis of colorectal cancer and how this impacts patients in their daily lives has not yet been focused on in detail. In addition, the disclosure of a diagnosis of cancer remains an issue of dispute, despite numerous publications in the past decades. It can be argued that Haller (1994; 2000) has already explored the phenomenon in depth. However, although Haller's study (1994; 2000), which was concerned to reveal the impact of colorectal cancer on the person's life, reached saturation, the heterogenous sample prevents illustration of particularities of the initial disease process. In addition, participants in Haller's study were mostly inter-

---

[101] For substantiation refer to section 5.2 of chapter 5.
[102] See sections 5.3 in chapter 5 of the thesis.

viewed once, with a retrospective focus. It can be argued that following patients longitudinally over a defined period of time (such as the first 13 months[103] of the disease process) will yield a more detailed picture of patients' feelings and reactions to the disclosure of a diagnosis of colorectal cancer and its impact on their lives.

In addition, literature attributes patients' feelings and reactions to specific phases in the disease process. It has been demonstrated that patients experience high levels of uncertainty before they leave hospital care after surgical removal of malignant growths (Galloway and Graydon, 1996; Mishel, 1981). Patients experience fears and anxieties, particularly with regard to their families (Black and Hyde, 2002). Stigmatisation is also raised as an issue, as colorectal cancer involves several sensitive issues such as fatal illness, death and dying, and the defecation processes (Black and Hyde, 2002; Flanagan and Holmes, 2000; Schulte, 2002). Therefore, a gap in the literature has been identified to research the experience of receiving a diagnosis of colorectal cancer and its meaning for the person concerned, as well as an interest regarding the interrelationships of an individual's feelings and reactions when confronted with a diagnosis of colorectal cancer.

3.5. Coping, Coping Models And Strategies

Whether or not a diagnosis is fully disclosed and adequate information is provided, or an individual way of giving bad news is found, affects patients deeply (Black and Hyde, 2002; Breaden, 1997; Morton, 1996; Senn, 1985). As a diagnosis of cancer means a threat to life, involving deep feelings of shock, fears and anxieties, pa-

---

[103] The time-span of 13 months is derived from the length of the interviewing for the study *The Da-sein of Colorectal Cancer*. See sections 4.2 and 4.7 in chapter 4.

tients are forced to come to terms with it somehow or another. How patients cope with a diagnosis of cancer is not only dependent on healthcare professionals' culture of imparting information, but also on the size of the threat and the patient's potential strategies to get to grips with such an event[104]. For a successful coping process to take place, it is necessary to take into account the importance of and differences between various phases of the disease process, as well as understanding of the meaning of a diagnosis of cancer in the individual's life. Coping strategies developed and employed by patients are seen as directly relating to the problems each phase generates, thereby offering causal explanations (Bräutigam and Meerwein, 1985; Kübler-Ross, 1996; Margulies et al., 1994; Meerwein and Bräutigam, 1998; Senn, 1997b).

Various models and theories for coping have been detailed in published works (Baldegger, 2001; Filipp and Aymanns, 1997; Klauer and Filipp, 1997; Kübler-Ross, 1996; Schröder, 1997; Schwarz and Hornburg, 1994; Thoman and Egg, 1985). Among these are phase-models that view the disease process in phases. Some of them are based on theories of coping with crises (Schwarz and Hornburg, 1994). Other models are based on stress theory and the impact of stress on human beings, thereby explicating patients' coping strategies when confronted with a fatal illness. They include theories that draw on personal resources to explain human coping strategies[105] (Schwarz and Hornburg, 1994: 219-229; Schröder, 1997: 319-347). Another way of coping with fatal illnesses is subjective theories about the causes of the disease[106]. For the purpose of this study, it is necessary briefly to address these different coping mechanisms. They will be outlined below.

Phase-models enjoy a high acceptance internationally, although empiric substantiation of their propositions remains limited (Klauer and Filipp, 1997; Schwarz and

---

[104] Confer to section 6.1 of chapter 6.
[105] For substantiation refer to section 6.1 in chapter 6.
[106] Also confer to section 5.2 in chapter 5.

Hornburg, 1994). Nevertheless, two phase-models - the one developed by Kübler-Ross (1996) and the second put forward by Senn and Glaus (1998) - will be addressed below as examples; whereas the second phase-model integrates aspects of stress and crisis theories. The model by Kübler-Ross (1996) addresses bereavement and consists of five phases. These are:

- Phase 1: Not accepting and isolation
- Phase 2: Anger
- Phase 3: Negotiation
- Phase 4: Depression
- Phase 5: Acceptance.

Each of the phases are explained in Kübler-Ross' writings (1996) and examples are cited that have been drawn from patients' experiences. Kübler-Ross (1996) worked primarily with terminally ill patients. Among the patients with whom Kübler-Ross enjoyed a relationship similar to a psycho-analytical relationship, were patients diagnosed with cancer. From discussions with the patients about their illness perceptions, Kübler-Ross (1996) developed the phase-model as stated above. Aspects of loss are central to Kübler-Ross' findings (1996). When an individual is confronted with a diagnosis of a fatal disease, it is believed that the first and foremost feeling is one of terrible loss. Individuals undergo a bereavement process in coming to terms with the fatal disease (Kübler-Ross, 1996; Weiss and Johnson, 1999). The phases of the bereavement process put forward by Kübler-Ross (1996) have provided some understanding about patients' coping strategies when confronted with a fatal disease. Examples demonstrate that healthcare professionals have to adapt to the patients' perception of their illness situation (Kübler-Ross, 1996: 32; 39). However, adaptations are sometimes difficult to make. Based on her findings, Kübler-Ross (1996) maintained that doctors and nurses caring for patients with fatal diseases need to learn more about the patients' disease management for better understanding. However, attribution of specific coping strategies to each phase remains problematic, despite descriptions. In addition, the social and illness background of patients participating in Kübler-Ross' (1996) research are not clearly documented. Explicit statements about the research process are lacking. Similarly, sampling strategies or other criteria are not described. Empirical substantiation of assumptions of phase-models such as the one developed by Kübler-Ross (1996) involves many constraints (Klauer and Filipp, 1997; Senn and Glaus, 1998: 57). Therefore, generalisability of phase-models like the one put forward by Kübler-Ross (1996) is questionable.

Although phase-models explicating patients' coping processes are viewed critically, the 'process of maturity' put forward by Senn and Glaus (1998: 58) will be briefly introduced. Six stages have been identified in the process of maturity (Senn and Glaus, 1998: 58). These are:

- Active refusal
- Aggressive refusal
- Partial refusal
- Depressive acceptance
- Conscious acceptance
- Transfigured acceptance

This process is not linear and thus the stages do not follow each other sequentially. Rather the process is lived in a spiral. The patient may go back one stage and then leap forward to another stage, and so on. Another difference with other phase models is the goal towards which patients move according to Senn and Glaus (1998). Patients' coping processes leads them to the acceptance of their illness situation and to find a way to make it a part of their lives[107]. Senn and Glaus (1998: 58) ex-

---

[107] See section 6.1 of chapter 6.

plained that the process of maturity may begin again when the patient is confronted with a relapse. Only thus can information deficits be explained according to Senn and Glaus (1998: 58). By emphasising the non-linear relationship between the phases in the process of maturity, Senn and Glaus (1998) offer an improvement to the interpretation of patients' coping processes as opposed to earlier phase-models such as the one by Kübler-Ross (1996) that suggests linear relationships between the phases.

However, empirical testing of coping models remains unsatisfactory due to the complexity of issues related to the models (Klauer and Filipp, 1997: 396ff). Research has not provided consistent evidence for generalising any of the coping models and in particular, no conclusive evidence has been found in relation to the phases in the coping models (Klauer and Filipp, 1997: 396ff). Another drawback of phase models is the attribution of patients' coping strategies to one or the other phase. Despite descriptions, difficulties remain in ranging coping strategies into phases of the models. Identification of the phase of patients' coping processes is not facilitated.

Qualitative findings hint at the importance of expressing feelings and denial (Klauer and Filipp, 1997: 396ff). There is also an indication that locus of control plays an important role in coping processes. In addition, it is important for patients to keep a balance in their psychological make-up (Schwarz and Hornburg, 1994: 229). However, scientific verification through qualitative and quantitative research of patients' coping processes when confronted with a fatal disease remains contradictory. Therefore, understanding of patients' reactions and coping strategies remains vague and support may not be adequate. A need was identified to provide more insight into patients' coping process when being diagnosed with cancer.

Another group of models explicating patients' coping strategies is based on the stress model developed by Lazarus (Faller, 1998: 36; Schröder, 1997: 319; Schwarz and Hornburg, 1994; Thoman and Egg, 1985). It is argued that fatal diseases are a stress factor in patients' lives. Therefore, people diagnosed with fatal diseases develop coping strategies to deal with the stress provoked by the illness. By perceiving the diagnosis of cancer as a source of stress, personal resources are introduced as being part of the stress coping mechanism[108] (Schröder, 1997: 320). Coping strategies based on stress theory may be used to predict patients' success in managing the fatal disease (Schröder, 1997). Research drawing on stress theory has focused primarily on attitudes of positive expectancy in order to explain potentially successful or failed attempts of coping with fatal diseases (Schröder, 1997). Positive attitudes toward the disease increase successful illness management, i.e., integration of the disease in the patient's life. Among these attitudes are dispositional optimism, internal locus of control and expectations of self-effectiveness (Schröder, 1997)[109].

- Dispositional optimism describes people's own expectations of positive events in their lives[110].
- Locus of control may either be internal or external. For positive illness management, an internal locus of control is supportive. An internal locus of control may also influence people's motivation to healthy living[111].
- Generalised expectations of self-effectiveness refer to optimistic expectations of competency, for example in relation to people's coping with pain (Schröder, 1997: 321ff).

However, theories about resources are not always reliable. Evidence for the effectiveness and application of the resources listed above are lacking and thus remain hypothetical (DeBoer et al., 1999; DeRaeve, 1997; Filipp and Aymanns, 1997; Hornung, 1986; Klauer and Filipp, 1997; Lalos and Eisemann, 1999; Schröder, 1997). It

---

[108] See section 6.1 of chapter 6.
[109] Refer to section 6.1 of chapter 6.
[110] Also confer to section 3.4 of this chapter about hope.
[111] See section 6.3 of chapter 6.

is also argued that research has failed to address self-esteem in detail, as well as other issues around self-regulation (Schröder, 1997: 321).

In the many possible coping mechanisms described in the literature subjective illness theories are also addressed (Faller, 1998; Filipp and Aymanns, 1997: 6; Klauer and Filipp, 1997: 381). Answers as to why an individual has fallen ill are important, particularly in the first phases of the disease[112]. Explanations and causes for the disease provide a basis for positive prediction by the patients themselves and therefore reinforce an internal locus of control. Thus, successful illness management is supported (Klauer and Filipp, 1997: 381). Later on, individuals attempt to gain control over their situation by developing methods of dealing with the threat of the ongoing illness[113] (Filipp and Aymanns, 1997: 6). It is argued that conceptualising the causes for the illness takes up the process of making sense of the fact of the disease. However, conclusive evidence that the diagnosis of a fatal disease challenges the sense of life has not yet been provided by research (Filipp and Aymanns, 1997: 8). On the contrary, patients' subjective theorising regarding the outcome of the disease has been a focus of empiric studies. There is evidence that patients believe their own contributions or lack of them will influence the outcome of the disease. Patients' positive beliefs reinforcing an internal locus of control will influence the disease process favourably (Filipp and Aymanns, 1997: 11). By contrast, a negative prognosis confirmed by healthcare professionals will destructively impact the disease process (Filipp and Aymanns, 1997: 11). Hence, expressions of support and contentment by the doctors and nurses affect patients' coping processes (Little et al., 1999)[114]. However, research on patients' coping strategies involving locus of control is sparce due to specific and limited research questions. Evidence for a

---

[112] Confer to section 5.2 of chapter 5.

[113] For substantiation check section 5.2 of chapter 5.

[114] See sections 5.4 and 6.2 of chapters 5 and 6 respectively. Subjects' statements substantiate this perspective.

strong influence on locus of control related to coping strategies remains inconsistent. Interrelatedness needs to be further explored.

Other well-researched areas of subjective illness theorising are patients' perceptions of potential vulnerability regarding fatal illnesses. It is argued, however, that despite clear evidence of fatal illness potential people are hardly encouraged to reflect on their behaviour or health conceptions. Improving personal life-style or behaviour is not requested (Filipp and Aymanns, 1997: 12). Subjective illness theories are identified as being a basis for the 'moment-by-moment coping' of patients diagnosed with fatal diseases. They attempt to find explanations and causes for their illness. In doing so, patients retain or regain the control over their lives that was taken from them by the disease (Filipp and Aymanns, 1997)[115].

Expert opinion about cancer diagnosis and its impact on a patient's life relates to the importance of managing fears and anxieties, or involve issues around autonomy and dependency (Faller, 1998; Meerwein, 1998; Senn and Glaus, 1998). Heidegger's Ontology of Dasein (1993a; 1996) demonstrates the importance of Fear and Anxiety[116] for people regardless of the manifestation of a fatal disease. Research so far has not exhaustively described the interrelationships of the impact of a cancer diagnosis on people's lives and the personal resources involved in successful coping. Therefore, further exploration of the impact of a cancer diagnosis on people and their lives is necessary.

---

[115] Refer to results and discussion chapters 5 and 6 sections 5.4 and 6.4 that support this finding.

[116] Fear and Anxiety have been briefly mentioned in section 2.2 in chapter 2, but will be introduced in more detail in section 5.1 in chapter 5.

3.6. Concluding Reflections

In summary, central to patients receiving a diagnosis of cancer are shock, fears and anxieties (Faller, 1998; Filipp and Aymanns, 1997; Glaus et al., 1997; Meerwein and Bräutigam, 1998; Schwarz and Hornburg, 1994). During the course of the illness, patients are confronted with disfigurement; an increasing dependence on health-care professionals and relatives; a limited range of activity due to therapeutic treatments, and growing social isolation due to stigmatisation of this patient group (Black and Hyde, 2002; Faller, 1998: 25; Leppin and Schwarzer, 1997; Meerwein, 1998: 63ff; Schulte, 2002; Senn, 1997b: 266ff). The medical care team assumes an important role in supporting the coping process of each patient by promoting favourable illness management (Fallowfield et al., 2002; Galloway and Graydon, 1996; Glaus and Meier, 1997: 221ff; Little et al., 1999; Meerwein, 1998: 63ff). Qualitative research focusing on patients' experiences of fatal diseases indicates the importance of various coping mechanisms such as dispositional optimism and denial for successful management of the illness situation. Within the coping processes, locus of control is also considered. However, conclusive evidence as to its importance has not yet been provided (Filipp and Aymanns, 1997; Klauer and Filipp, 1997: 397-398; Meerwein, 1998: 106ff; Schröder, 1997). It is indicated that successful coping with a fatal disease culminates in patients' acceptance of their mortality, as well as an integration of the disease into everyday life (Klauer and Filipp, 1997).

The incidence of colorectal cancer is increasing internationally. Oncology and related areas of interest have acknowledged the increase (Bain et al., 2002; Markowitz et al., 2002). Fatal diseases raise a variety of challenges for doctors and nurses. Nurses have a role as advocates for patients, as well as being mediators between patients and doctors (Glaus, 1998: 171). Therefore, nurses must understand what patients experience when they are confronted with a diagnosis of cancer and what this means for their lives. Literature has not yet described patients' experiences of receiving a diagnosis of colorectal cancer and what it means to their lives. In addition, evidence regarding patients' coping strategies when being confronted with a diagnosis of cancer remains inconsistent and inconclusive. Further investigation into patients' experiences is needed to elicit the interrelationship of patients' reactions and coping strategies[117].

Heidegger's Ontology of Dasein (1993a; 1996) proposes further insight into people's way of life as revealed in the study *The Da-sein of Colorectal Cancer,* which is concerned with patients' reactions when confronted with a diagnosis of colorectal cancer and what it means to their lives.

In the chapter that follows methodological considerations, research methods, trustworthiness and ethical considerations are addressed. It delineates the approach that unfolds. Findings explicate *The Da-sein of Colorectal Cancer* in the results and discussion chapters.

---

[117] Refer to chapters 5 and 6 of this thesis.

I remember a friend discussing Heidegger's writings. He said that reading *Being and Time* was like taking away layer after layer and still not arriving at the centre.

4. Methodology

The aim of the study *The Da-sein of Colorectal Cancer* was (A) to discern the meaning of the experience of receiving a diagnosis of colorectal cancer and its prognosis and (B) its implications for the nursing care of this patient group.

In this chapter methodological issues, including ethical considerations will be presented. The rationale for the research design developed for the study *The Da-sein of Colorectal Cancer* will be stated, followed by a description of the methods employed for data collection and analysis. To remain true to the tenets of Heidegger's philosophy (1993b; 1994) an account of pertinent issues regarding the researcher's Being-in-the-world will be offered. In addition, access to the research sites will be addressed; a description of the sample, including criteria for participation in the study, will be provided. A discussion of rigour in qualitative research will be followed by a description of the methods used to establish trustworthiness in this research. Ethical issues will be addressed at the end of this chapter.

4.1. Design

Before the research design for the study *The Da-sein of Colorectal Cancer* can be presented, it is necessary briefly to outline the two terms 'ontology' and 'ontic'. Ontology denotes a specific branch of metaphysical enquiry that is primarily concerned with being and, therefore, existence itself (Flew, 1979: 255; Kunzmann et al., 2001: 13). In contrast, the term 'ontic' refers to the empirical realm (Heidegger, 1993a: 53; 1996: 78). This difference has an impact on the research design.

In addition, Heidegger's Ontology of Dasein is a philosophy offering a phenomenological approach to human existence. According to Heidegger (1993b: 95), (philosophical) phenomenology will lead to the illustration of the 'Genuine Experience'[118]. Verbal and non-verbal communication is key to finding the 'Genuine Experience'. In communication, experiences are described and can be grasped as part of the individual's 'Self-world' (Heidegger, 1993b: 95). By contrast, the study *The Da-sein of Colorectal Cancer* is concerned with the ontic, empirical manifestations. Therefore, it is necessary to develop an empirical phenomenological approach[119] that draws on Heidegger's Ontology of Dasein to investigate the experience of having received a diagnosis of cancer and what this means for the human being concerned. In nursing, phenomenology refers to research approaches that describe and expose human experiences (Burns and Grove, 1993; Hallett, 1995; Koch, 1995; Oiler, 1981; Omery, 1983; Polkinghorne, 1989; Rather, 1992; Taylor, 1993). In this study empirical methods that have been formulated in nursing, and that are attributed to phenomenology, will be drawn upon to explicate methods for data collection. For the purpose of this study, the empirical phenomenological design drawing on Heidegger's Ontology of Dasein (1993a; 1996) involves a constructivist approach (Denzin and Lincoln, 1994: 128-129) as a theory has been formulated[120].

Phenomenology in nursing allows for a wide range of methods for data collection, such as observation, interviews, field notes, diaries, and the visual arts (Burns and Grove, 1993). This thesis presents the study as descriptive, exploratory research, including in part constructivism. This process involved:

- interviews as dialogues with patients who were recently diagnosed with colorectal cancer, spanning thirteen months in total

---

[118] Heidegger elucidates this further in *Grundprobleme der Phänomenologie* (1993b).
[119] In nursing, the term ‚phenomenology' denotes a research approach and, therefore, is concerned with the empirical realm (Beck, 1994; Omery, 1983; Paley, 1998; Plager, 1994). For the purpose of this study, the expression 'empirical phenomenology' will be used to refer to the design developed to investigate *The Da-sein of Colorectal Cancer.*
[120] Refer to chapter 7 on *The Omnipresence of Cancer.*

- field notes
- a personal diary
- additional sources of information
- Colaizzi's method of transcript analysis (Haase, 1987: 66-67).
- Linkage to Heidegger's Ontology of Dasein as described in *Being and Time* (1993a; 1996)
- Explication of *The Omnipresence of Cancer*[121].

4.2. Interviews

In qualitative research, interviews are the main instruments for data collection (Denzin and Lincoln, 1994; 1998). Interviews may be structured or unstructured, using closed or open questions. Depending on the research design and for the convenience of the subjects, interviews can be conducted face-to-face, by telephone, or in a group. Interviews may be conducted once only or several times, or over a defined period of time. The interview schedule is determined by the choice of the phenomenon under investigation, the selection of the appropriate research design, and even budgeting. For the purpose of this study, to elucidate *The Da-sein of Colorectal Cancer*, the use of unstructured interviews, conducted in a dialogical way, were employed (Burns and Grove, 1993; Gray, 1994; Rose, 1994; Sorrell and Redmond, 1995). Thus, a description of *The Da-sein of Colorectal Cancer* was generated. Interviews conducted in a dialogical way take up the tenets of Heidegger's Ontology of Dasein (1993a; 1996).

---

[121] See chapter 7.

4.2.1. Engaging in Dialogue

By using the term 'engaging in dialogue'; an unstructured approach to interviewing is implied. In contrast to structured or semi-structured approaches to interviews, the form chosen here is considered to provide a platform for both the subject and the researcher to build up a dialogue. When conducting an empirical phenomenological study, engaging in dialogue with subjects is most suitable and appropriate according to Parse (1996; 1998). By engaging in dialogue, the researcher is with the subject in 'true presence' (Parse, 1996: 57; 1998: 64-65). Being in 'true presence' means that the researcher is centred on the subject and the content of the dialogue. The researcher is not obliged to prepare a list of questions. Parse (1998: 64) recommends that the dialogue should be opened with one or two initiating questions. The researcher is expected to follow the lead of the subject and to join in the flow of the dialogue. Silences and pauses are viewed as important parts of the dialogue. Prompting the subject is only considered valid in the form of reflecting a previous train of thought or by gently urging dialogue forward by the use of phrases such as: "and then . . .?" or: "go on . . ." (Parse, 1998: 64-65). Questions, catchwords or themes can also be prepared to focus on the phenomenon under investigation (Fielding, 1994). Two probes are considered enough in such circumstances (Sorrell and Redmond, 1995). The subject may be asked to tell again a certain part of her story. 'Recapitulation' (i.e., telling something a second time) may yield details that have not been mentioned or included earlier. There are also silent probes as it is possible that neither subject nor researcher are able to express themselves in words or non-verbal gestures. The researcher must be aware that silences naturally occur and therefore must not become uncomfortable in interviews (Sorrell and Redmond, 1995: 1121).

From a Heideggerian point of view (1993a and b), engaging in dialogue and using the above techniques invites subjects to describe their Being-in-the-world[122]. It is therefore possible to take up Heidegger's Ontology of Dasein. Subjects determine the pace of the discussion, and where it leads. They follow their own train of thought. In communication, subjects disclose their Being-in-the-world, their Self-world[123] and thus tell of their experiences. Subjects not only give themselves wholly as Dasein[124] into the dialogue, but the researcher also takes part with her Being-in-the-world[125]; both are actors. They are with each other in the dialogue situation, which allows for each actor to reveal their Being-in-the-world in discussion. Both shape the dialogue situation (Sorrell and Redmond, 1995; Parse, 1996; 1998). The Heideggerian belief is that an individual is as much shaped by her world as the world is shaped by the individual. This is true for the dialogue situation (Heidegger, 1993a; 1996; Koch, 1995). Engaging in dialogue about a phenomenon may therefore have a positive or even 'healing' effect, as Sorrell and Redmond (1995: 1120) indicate, for both subject and researcher. Articulating experiences means at the same time confrontation with them (Parse, 1996; 1998). By drawing on Parse's writings (1996; 1998) to develop a research method for investigation of *The Da-sein of Colorectal Cancer*, Heidegger's perspective on Dasein is not contradicted.

4.2.2. Dialogue Schedule

Before meeting potential subjects, a dialogue schedule with prompts was developed for this study. As the focus of the dialogue was the experience of having been diagnosed with colorectal cancer, it was appropriate to develop the prompts accordingly.

---

[122] Compare with section 2.1.
[123] See sections 2.1, 2.4 and 2.5.
[124] See section 2.8 of chapter 2.
[125] Also refer to section 4.4.1 of this chapter.

Opening Dialogue Prompts:
Tell me how and when you first heard you had cancer.
How did you feel about this?

The dialogue opening above was thought to be useful after the initial contact had occurred. In the following dialogues, attempts were made to bring subjects back to the hospital stay and the events connected with the diagnosis of colorectal cancer. It was assumed that subjects would then be led to reflect on their situation. The focus was on changes in the subjects' lives. In case of differences in life from before the receipt of the diagnosis of colorectal cancer, it was of interest as to what had changed and why.

Dialogue Prompts:
How do you feel at the moment?
What did your illness change in your life?

A provisional schedule was drafted to conduct the dialogues with subjects. In contrast to Haller (1994; 2000), the focus of the study *The Da-sein of Colorectal Cancer* was on the early stages of the illness, and in particular the beginning of the illness, being told about having colorectal cancer, its prognosis and the initial treatments.

Prior to data collection, at least two contacts with subjects were considered necessary before agreement to participate could be obtained. Initial contacts with subjects at the beginning of the study were expected to serve two purposes. Firstly, the researcher and the subjects would get to know each other. Secondly, the researcher assumed that the first few months were the most intense in the subjects' experience and planned the schedule outlined below.

Schedule:
Month 1: one interview every week.
Months 2 and 3: one interview every other week.
Months 4, 5, and 6: one interview per a month.
Month 7, 8, 9, 10, 11, and 12: one interview every other month.
(These months refer to the time after the initial contact of researcher and subject).

Initial contacts were used to establish a relationship that allowed the researcher to become part of the subjects' world; thus taking up a Heideggerian point of view (1993a and b). In these first contacts the researcher introduced herself to potential subjects and gave them information about the study. The researcher handed the subjects information letters (Appendix C). As the focus of the study was the subjects' experience of having received a diagnosis of colorectal cancer, it was considered fruitful, and was ethically obligatory to ask the subjects for informed consent (Appendix D). Another meeting was then arranged to provide the potential subjects with time to think about participation in the study. Only when subjects consented with their signature to participate in the study was it ethically possible to continue data collection. Therefore, the initial meeting was not suitable for initiation of data collection with a tape-recorder.

Dialogue prompts developed for the initial meeting proved to be problematic. Subjects appeared unable to comprehend them. They asked the researcher "What is this all about" and "What do you want to know". The prompts were therefore reconsidered and re-phrased as:

How are you?

This prompt proved to be much more successful. By employing this common introduction to any discussion, the subjects felt invited to talk about themselves. The prompt's suitability was once more confirmed as subjects related their experiences freely and directly. In the initial contacts the subjects talked primarily about the appearance of the illness and how they came to be in hospital.

The initial dialogue schedule was only marginally adhered to for subsequent meetings. It was considered more important for subjects to agree to discuss their feelings of their own free will, rather than pressing for a contact within the limits of the dialogue schedule. These tactics proved to be successful, as the control in the dialogues dates and locations remained in the subjects' hands. They decided when and where the next contact would be scheduled, what the discussion would be about and when the dialogues would come to an end. The length of the dialogue schedule also varied. It was dependent on the subjects' convenience. Another important factor that influenced the length of the discussions was the subjects' health. In subsequent contacts the researcher introduced a tape-recorder. Dialogues were transcribed verbatim to facilitate analysis procedures (Sandelowski, 1993). All raw data were kept locked, unless they were undergoing analysis.

4.3. Field Notes

One method alone, e.g., dialogue, is seldom sufficient in qualitative research (Parse, 1998). It is necessary to record as much as possible about the study process, the research environment, and the researchers themselves in field notes (Bailey, 1996; Koch, 1994; Miles and Huberman, 1994). To gain understanding of a phenomenon from a Heideggerian perspective, it is important to obtain a description of the subjects' world[126], as there is reciprocity in influence between the individual and the world (Heidegger, 1993a; 1996; Koch, 1995).

For this study, it was decided to record (1) the setting of the subjects' world, (2) what happened during the dialogues and (3) telephone conversations as field notes. Notes about the setting of the subjects' world (1) were recorded immediately after the dialogues. This included any information from nurses, doctors, subjects' friends or family members. It had been planned to take notes by hand during the discussion (2), as non-verbal communication is considered as important as verbal (Begley, 1996). However, this proved to be limiting and obstructed the researcher's true presence.

---

[126] See section 2.1 in chapter 2.

In addition to face-to-face dialogues, telephone calls took place between the subjects and the researcher (3). The number of personal meetings with the subjects varied over the 13 months period. To guarantee continuity and to keep close contact, as well as to arrange for another meeting, the researcher telephoned the subjects. In these calls, subjects talked about their well-being, their illness and their experiences. These discussions were, therefore, recorded as field notes. All sources of field notes offered meaningful references for analysis. They illustrated the subjects' Being-in-the-world and offered additional insight into their Self-worlds.

4.4. Personal Diary

In contrast to experimental research, subjects in an empirical phenomenological investigation cannot be separated from the researcher and studied from a distanced position. In a study using a Heideggerian approach, the researcher is as much involved as the subjects are themselves (Heidegger, 1993b; 1994; Parse, 1996; 1998). By engaging in dialogue, the researcher is introduced into the subjects' Being-in-the-world and vice-versa. It was therefore necessary for the researcher to monitor her own Being-in-the-world (Bailey, 1996; Koch, 1994; 1996; Walters, 1995). The researcher needed to take account of what is happening in and around her. Keeping a diary[127], which started in January 1998, was considered useful to reflect on the impact the study had on the researcher as it progressed (Beck, 1994; Burns and Grove, 1993; Koch, 1996; Walters, 1995). Recording events and issues about the study became a way for the researcher to monitor and manage profound changes in her thinking. The dairy became a record of the researcher's personal growth, as

---

[127] As the entries in the diary are very personal, they are not included in the bulk of the thesis. However, for more details about the research process refer to section 4.4.1 of this chapter.

well as a revelation of the researcher's understanding of the phenomenon studied. To remain true to the tenets of Heidegger's philosophy (1993b), however, the researcher's Being-in-the-world needs to be stated[128]. Pertinent issues that the researcher encountered during the research process are related in 'My Being-in-the-world' (section 4.4.1).

4.4.1. My Being-in-the-world

In the first month of data collection I experienced profound changes in my mood. In the initial meeting with the first subject, I felt enthusiastic and was convinced of the need for my study. S1[129] agreed to take part immediately. This early success boosted my motivation. I hoped that the mood of elation would persist, but discussions with medical personnel undermined this sense. In subsequent meetings with potential subjects, I felt more hesitant. It did not come as a surprise that the following five subjects were not interested in participating in my research. The general tenor was that they did not mind talking to me whilst they were in hospital about what had happened to them. However, they would object continuing dialogues following discharge from hospital. Why would the patients not want to participate in a study following hospital care, I asked myself? Based on the statements with which subjects responded to my approach, I concluded that they wished to 'close the book' after they left the hospital. I began to sense my research would not move forward because I could not recruit subjects. Disaster was looming. Following a review of my approach to potential subjects[130], I was more successful in getting them to participate in my study. This success produced immense relief in my mood.

When returning to bedside practice, I noticed profound changes in my professional skills. My personal approach to patients was refined and supported the development

---

[128] As the researcher's Being-in-the-world is of a personal nature, the account will be written in the first person singular.

[129] Also see Appendix E.

[130] Compare with section 4.2.2 of this chapter and Appendix F.

of a therapeutic relationship. Many positive encounters with patients and rewarding in-depth dialogues with most of them resulted. It was a new and overwhelming experience to find myself so attuned to patients' needs and problems.

During analysis of the data my close relationship with the subjects became an obstacle. When immersing myself in the subjects' accounts I felt transported back into the actual dialogue situation. All details about the dialogue were present again and became emotionally overwhelming. Thus, I was less and less able to find the necessary objectivity needed to identify significant statements in the patients' accounts. My supervisor noticed the loss of distance, as analysis was not progressing satisfactorily. I felt this as well. Hence, I decided to involve my supervisors and experts from the panel in the analytical process[131]. Only then was it possible for me to develop the necessary distance to continue analysis satisfactorily. However, during the hiatus when analysis was not progressing, it became apparent that other sources of information beyond the subjects' transcripts would help illuminate the study.

4.5. Other Sources of Information

To obtain more detailed information about the subjects' Being-in-the-world, the researcher suggested that they record important thoughts, dates and events in a note-book provided by her. Only one of the subjects made use of the booklet. Another subject kept a record of her own about the entire illness period. The other subjects did not appear to have much interest in recording events around their illness. These records were included in the analytic process and completed the field notes.

---

[131] Refer to Appendix F.

4.6. Colaizzi's Method of Analysis

Heidegger (1993a: 37; 1996: 62) stated:

> "The phenomenology of Dasein is a hermeneutic in the primordial signification of this word, where it designates this business of interpreting." (Heidegger, 1993a: 37; 1996: 62).

It is further maintained that the hermeneutic circle should be employed to analyse (philosophical) phenomenological data (Heidegger, 1993a and b; 1994). However, Heidegger (1993a; 1996) proceeded to describe the Ontology of Dasein, providing only minimal information for employing the actual hermeneutic process (Heidegger, 1993a and b; 1994)[132]. Hermeneutics is considered to be a theoretical approach that lacks detailed practical advice for analysis (Käppeli, 1998; Grondin, 2001: 14, 133ff). Researchers interested in hermeneutic analytical processes need to look elsewhere for support. Colaizzi, along with others, provided a more concrete analytic approach to empirical phenomenological data (Colaizzi, 1978; Valle and Halling, 1989). Whether or not Colaizzi drew on Heidegger's philosophical phenomenology is a matter of dispute (Koch, 1995; Walters, 1995). Despite the controversy and the argument that a structured approach, such as Colaizzi's analytic method is not consistent with Heidegger's perspective of the hermeneutic circle and the ideal way to interpret empirical phenomenology, the lack of guidance by Heidegger himself promoted its usage.

A few phenomenological studies in nursing can be found that have made use of Colaizzi's analytic approach (Chambers, 1998; Dillon and Stines, 1996; Haase, 1987; Kralik et al., 1997; Phipps, 1993; Sowell, et al., 1991). However, there is some inconsistency over the number of analytical steps described by Colaizzi. Haase (1987: 66-67) not only listed the analytical steps in detail, but also provided a guide to

---

[132] Also refer to Grondin (2001: 133ff).

their usage. Hence, Colaizzi's analytical procedure put forward by Haase (1987: 66-67) was applied to this study. The process involves:

1. Acquisition of a sense of meaning through listening to and transcribing the tapes.
2. Extraction of significant statements.
3. Formulation of significant statements into a more general restatement.
4. Formulation of a statement of meaning and validation of that meaning by a panel of experts.
5. Organisation of formulated meanings into themes, theme clusters, and theme categories.
6. Integration of themes into an exhaustive description of the phenomena of interest.
7. Formulation of the statement of the essential structure.
8. Validation of the essential structure by study participants (For examples of points 5 to 8 see the results and discussion chapters).

Heidegger (1993a; 1996) emphasised that the philosophical phenomenology of Dasein must have a holistic approach and perspective. Phenomenology in nursing research is also considered to have a holistic approach to and perspective of the phenomenon under investigation (Beck, 1994; Koch, 1995; 1996; Omery, 1983; Paley, 1998). Therefore, the researcher did not include computer supported analysis in the analytic process. In addition, Colaizzi's analytical procedure put forward by Haase (1987: 66-67) does not include computer supported analysis. To stay true to the tenets of philosophical phenomenology according to Heidegger (1993a and b; 1994; 1996), as well as to follow the first step in Colaizzi's analytical procedure, the researcher immersed herself in the data and searched for meaning. Such a process is considered appropriate in studies with phenomenological perspectives (Käppeli, 1998). Immersion in the data proved to be a very difficult process. On several occasions the researcher became too personally involved with the patients and the data. Objectivity was lost[133]. When this occurred, the researcher sought the support of her supervisor, as well as the expert panel (Appendix F). Both sources of support provided the necessary grounding.

It became clear that the first four steps in Colaizzi's analytical process only became possible to execute by first including several phases of condensation. The amount of data collected during the 13 months was so enormous that it had to be condensed to a manageable level. Each transcribed interview was at first reduced to a narrative text comprising the most significant statements. Then all data (i.e., the interviews and the field notes from each subject) were reduced to narrative texts. In the subsequent step, the narratives were perused for the themes 'illness', 'family and friends' and 'stoma'. 'Illness' was selected because of its association with Heidegger's Care and Temporality (Heidegger, 1993a: 131; 1993a: 192; 1993a: 328; 1996: 169; 1996: 237; 376) as embracing structures of Dasein's Being; it's finitude of human existence and its Being-towards-death (Heidegger, 1993a: 250ff; 1996: 293ff). 'Family and friends' were selected because of their association with Heidegger's Existentials of the They, Being-with and Solicitude (Heidegger, 1993a: 118ff; 1996: 155ff). 'Stoma' was chosen due to its interconnectedness with Being-in-the-world (Heidegger, 1993a: 54ff; 1996: 82ff). At this point, it was possible to apply steps two to four of Colaizzi's analysis as described by Haase (1987: 66-67). Only then was it possible for the researcher to formulate a statement of meaning that was then presented to the panel of experts (Appendix F). Based on the statement of meaning, the essential structure[134] was developed and presented to the subjects for validation. The exigency of Colaizzi's analytical procedure (Haase, 1987: 66-67) to formulate an essential structure constitutes a deviation from the descriptive characteris-

---

[133] Also see section 4.4.1 in this chapter.

[134] The essential structure is presented in the story on pages 14ff of this thesis.

tic of Heidegger's philosophical phenomenology, as well as from phenomenology in nursing research. By stating the essential structure, the realm of constructivism[135] is entered. Data analysis facilitated understanding the experience of receiving a diagnosis and prognosis of colorectal cancer and what it means to the future life of the individual, as well as the illustration of *The Da-sein of Colorectal Cancer*.

4.7. Research Environment And Sample Population

The study *The Da-sein of Colorectal Cancer* was conducted in Switzerland. Access to the research environment and the sample, as well as inclusion and exclusion criteria for participation in the study will be described below.

4.7.1. Access to Site

The proposal for this study was presented to six hospitals in Switzerland. The first contact was made in June 1998. By November 1998, three hospitals had refused the study. Only the Spital Limmattal in Schlieren/Urdorf had consented by that date. The following approach to the patients was suggested by a nurse manager that met the approval of all chief consultants of the medical and surgical department of this hospital. The nurse manager suggested that in order to obtain information about potential subjects, the researcher should contact the senior nurses of the surgical and medical departments. At the same time, the researcher should contact the senior consultant responsible for the patients concerned and arrange a meeting the same day. The senior consultant should then be asked to give consent for patients to participate in the study (Appendix B). After having received oral approval of the

---

[135] See Denzin and Lincoln (1994; 1998).

senior consultant, the researcher should contact the nurses caring for the potential subjects. (Usually, the completed consent form (Appendix B) was returned to the researcher a considerable time later). Only, when the researcher had received information from all healthcare professionals involved, should she approach the potential subjects themselves. This approach became the routine. In addition, nurses and doctors received a letter of information about the study's aims from the researcher (Appendix A).

From the third week in December 1998 onward, the researcher contacted the senior nurses of the surgical department of the Spital Limmattal in Schlieren/Urdorf, asking for potential subjects for the study. To establish a closer relationship with nursing management, it was arranged for the researcher to meet the ward sisters and senior nurses concerned. The meeting proved fruitful for the ward sisters and senior nurses, as they were able to ask questions about potential subjects and recruitment of patients to the study.

Besides the Spital Limmattal in Schlieren/Urdorf, the Stadtspital Waid in Zurich was contacted to obtain a sufficient number of subjects for the study. Its management consented to the study in December 1998. However, by mid-January 1999, neither the Spital Limmattal in Schlieren/Urdorf, nor the Stadtspital Waid in Zurich identified any potential subjects for the study.

The Cantonal Hospital in Aarau sent the study proposal to their Ethics Committee for review. On 10 December 1998, the Ethics Committee of the Cantonal Hospital in Aarau approved the study. However, several changes were imposed. These pertained to grammar and expression used in the proposal[136]. On 14 January 1999, the researcher contacted the head of the surgical department of the Cantonal Hospital in Aarau. The senior surgeon anticipated that there should be sufficient potential subjects to be found in that hospital. However, as the next step, the researcher was

---

[136] The proposals were submitted in German to all the hospitals.

asked first to contact the chaplain of the hospital to work on a structure of backup for the subjects, should it become necessary. This was done, however, during the study; none of the subjects ever contacted the chaplain. Besides talks with the chaplain, the researcher contacted nursing management to arrange for access to the site and patients.

4.7.2. Sample

A statistical sampling procedure is often not possible in qualitative research. Instead, purposive or theoretical sampling procedures are used (Burns and Grove, 1993; Käppeli, 1998). Purposive sampling means selecting subjects by using the criterion of availability. By contrast, theoretical sampling involves criteria that allow for the opportunity to explore the phenomenon in all its dimensions and all its properties. Criteria in theoretical sampling are defined to encompass issues relevant to the themes emerging from analysis. Therefore, a homogeneous sample of subjects can be obtained (Strauss and Corbin, 1998: 201ff). For an empirical phenomenological study, sampling subjects who have experienced the phenomenon under investigation and who are able to express themselves clearly, is sufficient, according to Colaizzi (1978).

For this study, a mixture of all these qualitative sampling procedures was used. Thus, the formulation of inclusion and exclusion criteria for subjects to participate in the study was necessary. Several potential subjects were approached. In all, 15 subjects were approached within a five month period. In total, seven subjects agreed to participate in the study (Appendix E). They took part in dialogues during a time-span of six to thirteen months and thus agreed to interviews after the hospital discharge. The seven subjects had recently been given a diagnosis of colorectal cancer (Appendix E). Due to sampling strategies, the initial contact with potential subjects took place in either of the above mentioned hospitals. All subjects had, by then, undergone surgical removal of the malignant growth. They were approached two or more days after the surgical intervention, because contact on the day of admission was considered too stressful. Potential subjects for the study were adult females or males over the age of 18, who had signed the consent form (Appendix D) and whose senior consultant had given permission for them to participate in the study (Appendix B). Additionally, the researcher consulted the nurses in charge to determine the health condition of the potential subject. Overall agreement by the medical team was considered sufficient confirmation to approach potential subjects. The lengthy procedure proved to be very helpful in the selection of potential subjects. By contrast, it was not possible to include patients in the study who were below 18 or mentally ill. Refusal by the consultant, or a report of a poor health condition constituted grounds for exclusion from the study. Patients who did not agree to be interviewed after hospital discharge could not be included in the study either. This last criterion was the main reason that more than half of the patients approached could not take part in the study.

It had been planned to inform the patients' general practitioner about the study. However, that only became necessary in one case. All other subjects remained under the supervision of the hospital for the duration of the study and the surgeon who was contacted at the beginning of the study.

Contrary to the researcher's belief that several contacts would be necessary to obtain the subjects' consent, most subjects agreed to participate during the initial contact. Only two subjects required time to consider whether they would participate. It was unexpected, but welcome to find that subjects described their experiences of having colorectal cancer during the initial contact. The revised prompt proved to be effective[137]. These discussions were not tape-recorded, despite the fact that subjects did not need additional time for deliberations. Thus, the re-

---

[137] Refer to section 4.2.2 in this chapter.

searcher had to rely on field-notes. Details from initial discussions were recorded as field notes in all cases except one.

Usually, the date of the next contact was agreed at the end of the last discussion. Subjects were asked if they would like to meet with and talk to the researcher again. A date and location was then agreed upon. Usually, the researcher was invited to meet the subjects in their homes. These contacts focused primarily on the subjects' feelings and experiences in relation to the illness, and how it affected their everyday life. To initiate the discussions the revised prompt that had proved to be very efficient, was used.

4.8. Issues of Rigour

When conducting a qualitative study, issues of rigour must be addressed. Issues of rigour vary in qualitative research, compared to quantitative research (Sandelowski, 1993). The next section addresses this issue.

4.8.1. Quantitative Versus Qualitative Criteria For Research

In nursing science there is an on-going debate about qualitative and quantitative research paradigms (Bryman, 1984; Holmes, 1990; Sandelowski, 1993). This has resulted in a debate about the criteria required to demonstrate rigour. The most widely used criteria are reliability, external and internal validity originating from the quantitative paradigm. It is argued that quantitative criteria are critical in nursing research in order to obtain acknowledgement of other scientific disciplines (Brink, 1991; Sandelowski, 1993).

However, quantitative criteria have shortcomings in relation to qualitative research. Quantitative definitions are based on quantifiable and measurable issues that cannot be found in qualitative research. To provide more appropriate criteria for qualitative research, several concepts have been proposed (Beck, 1993; Burns and Grove, 1993; Guba and Lincoln, 1985; Polit and Hungler, 1993). In opposition to the compact criteria for quantitative research, there is considerable dispute about the proposed concepts required to establish rigour, or trustworthiness as it is termed, in qualitative research (Guba and Lincoln, 1985). This may be part of the reason that quantitative criteria prevail in qualitative research. For this study quantitative criteria are insufficient to demonstrate rigour. Trustworthiness must be evident. Since there is not one set of criteria, but several overlapping propositions that reflect trustworthiness, selecting the best version is important. Guba and Lincoln (1985) proposed truth value, applicability, consistency, and neutrality as one set of criteria. Beck (1993) and Sandelowski (1993) have detailed these four criteria, renaming truth value as credibility. The following criteria consisting of credibility, applicability, consistency, and representativeness are more accepted than others (Beck, 1993; Burns and Grove, 1993; Guba and Lincoln, 1985; Sandelowski, 1986). This latter set of criteria is demonstrated in the findings of *The Omnipresence of Cancer*.

4.8.2. Establishing Trustworthiness

The process of establishing rigour in the study *The Da-sein of Colorectal Cancer* is explained below. Criteria to be addressed are: credibility, applicability, consistency and representativeness.

4.8.2.1. Credibility

Credibility corresponds with the quantitative criterion 'internal validity' that determines, if at all, how much the independent variable influences or transforms the dependent variable (Beck, 1993). In qualitative research, credibility is a measure of how well the phenomenon has been described in a study.

Credibility in this study was developed by the use of transcripts of dialogues, field notes and diary. By transcribing the dialogues, subjects' descriptions of the phenomenon was detailed and prepared for condensation and analysis. In the dialogues subjects articulated their Being-in-the-world[138]. The field notes provided an account of the particularities in the dialogues, of the setting, and about further contacts with the subjects. They were also used to delineate the subjects' progress during remission. As the field notes were recorded by hand, by the researcher, a different viewpoint to the subjects' Being-in-the-world was offered. From the diary the researcher's involvement in the study, as well as her Being-in-the-world was revealed[139]. This offered a revelation of the researcher's understanding of the phenomenon. Therefore, the researcher's and the subjects' viewpoints became distinguishable. This was considered very important in the analytic process. Employing various sources of data collection produced a holistic perspective of the phenomenon, as well as a description from different angles.

Statements from the condensation process and findings from the data analysis were presented to the subjects for review and agreement. They, therefore, contributed actively and determined whether the analysis faithfully captured what they had told the researcher during their dialogues. Subject validation is an important way of establishing and enhancing credibility and accuracy of the data (Beck, 1993; Plager, 1994). In furthering credibility, as previously noted, an expert panel was assembled in Switzerland (Beck, 1993; Burns and Grove, 1993). The expert panel reviewed and commented on the statements constructed from the condensation process, as well as on data analysis and subsequent findings (Appendix F).

---

[138] Refer to section 2.1 in chapter 2.

[139] Confer with section 4.4 in this chapter.

4.8.2.2. Applicability

The counterpart to the qualitative criterion applicability is the external validity criterion of the quantitative paradigm. External validity is used to determine whether the results of a study are generalisable to other populations (Beck, 1993: 264). In the quantitative paradigm, sampling procedures would aim at a large statistically relevant sample, as generalisability increases with a larger number of subjects. In qualitative research this is not possible. Therefore, in qualitative research, applicability relates to the 'fittingness' of the research findings. Evaluating the applicability of a study determines how well the research project fits into a different context than the original (Beck, 1993). Using an expert panel to review the research proposal and follow the study promoted applicability. Data and findings were, therefore, substantiated in the process of conducting the research. By presenting parts of the study findings at various conferences and workshops, applicability was further enhanced (Shaha, 2000a and b; 2001; 2002; Shaha and Cox, 2001; 2003)[140]. Discussion about the findings promoted reflection and determination of applicability. Through dissemination, the study findings were made available to a large audience. Therefore, critical evaluation through reflection was enhanced.

4.8.2.3. Consistency

The quantitative criterion of reliability can be viewed as a counterpart to the qualitative criterion of consistency (Beck, 1993; Guba and Lincoln, 1985). Consistency appears to be interchangeably used with auditability. The qualitative criterion of consistency reflects the extent to which other researchers can follow the study and conduct it themselves (Guba and Lincoln, 1985). To guarantee consistency the audit or decision trail that delineates all decisions taken during the course of the study, needs to be accessible and understandable. It is, therefore, necessary to provide transparency about the decision making processes in the research project (Beck,

---

[140] Consult Appendix H.

1993). Field notes[141] and a diary[142], in which elements relevant to the study were recorded, a panel of experts monitoring the analytic process[143], as well as presentation and dissemination of study findings at various stages in the condensation and analytical process[144] were used to establish the decision trail for this study.

4.8.2.4. Representativeness

There is no quantitative counterpart to representativeness in other criteria. Representativeness is also known as confirmability or neutrality (Guba and Lincoln, 1985). It establishes whether the presented data really represents the views of the subjects. As such representativeness is extremely important. It determines whether the data and the analysis accurately represent the truth as the subjects saw it and trusted the researcher with it (Beck, 1993; Koch, 1994).

To establish representativeness in this research, the subjects were asked to review statements from the condensation process, data analysis, and to confirm the findings. The subjects did not like to read the condensed statements, or the analysis of their dialogues. Despite this they commented critically on the presented material. The analysis (i.e., the essential structure)[145] in particular was considered in detail. The descriptions given to the subjects reminded them of their difficult experiences in being confronted with the diagnosis and treatments. Reviewing and thinking again about the difficulties the subjects had experienced during those days, weeks and months, were difficult. All subjects indicated they were near tears and felt decidedly unwell when reading the analysis. As the researcher had anticipated such reactions, she made sure that the subjects were able to meet with her to discuss their feelings. Interestingly, opinions and feelings varied when the subjects read the essential structure that was represented in a story. All subjects, except one, said the story represented their feelings and experiences accurately. Vehement protest

---

[141] Compare to section 4.3.
[142] See also section 4.4.
[143] Also consult Appendix F.
[144] Compare to Appendix H.
[145] See pages 14ff for the essential structure represented in the story.

against the story came from only one subject who said the story was a complete make-up and fiction.

To enhance representativeness further, the expert panel was asked to evaluate the results of the condensation and analysis and confirm accuracy in representing the phenomenon being studied. They were also presented with the essential structure and agreed that it represented the essence of *The Da-sein of Colorectal Cancer*, i.e., *The Omnipresence of Cancer*[146] (Appendix F).

4.9. Ethical Considerations

As stated in previous sections of this chapter, potential subjects were informed by the researcher about the study. They were given an information letter (Appendix C) that covered the purpose and nature of the study. On the information letter, the researcher's name and contact details were listed for further information or any issue that might arise during the study. An additional letter of information covering similar issues was given to the nursing and medical staff (Appendix A). The subjects' senior consultants were also asked to sign a consent form (Appendix B). Efforts were made to keep all healthcare professionals involved with the subjects informed about the study and its progress.

Participation in the study was completely voluntary. Subjects were told that participation in the study would not influence their medical treatment. The decision to take part was entirely up to the subjects themselves. Potential subjects were only accepted into the study if they agreed to participate by signing the consent form

---

[146] Consult chapter 7.

(Appendix D). After agreeing to participate, subjects were given a copy of the signed consent form. The researcher endeavoured to emphasise as often as possible that participation was voluntary. None of the subjects, who agreed to participate in the study, withdrew. In total 15 patients were approached, of which seven[147] agreed to participate by filling in the form (Appendix D). The remaining eight patients, who did not consent to participate in the study, reasoned that they were willing to talk about their experiences at the moment of approach, but not after discharge from hospital. They did not want to participate in a study that extended beyond their hospital stay. None of the subjects or the remaining eight patients unwilling to participate were coerced into participating in the study. There were no repercussions, ill effects or penalties at the time of withdrawal, or at any other time. Neither the subjects nor the healthcare professionals received any payments.

Senior surgeons and medical directors felt that there was a possibility that subjects discussing their illness would feel distressed. Despite their fears, this did not occur. Subjects agreed unanimously on conclusion of the dialogues that they benefited from participation in the study.

All material - dialogue transcripts, field notes and diary - were confidential. All data collected remained with the researcher and was kept locked. No identification of subjects was possible as they were allocated numbers. Names were not used. Personal details of the subjects were kept on a separate diskette from the interview data. During analysis, only the researcher had access to the data. The supervisor and expert panel were provided with anonymised data.

The chapter that follows presents the results of analysis using Colaizzi's method. It explicates the two sub-categories that form the main category - *The Omnipresence of Cancer* - that answers the primary question:

> "What is *The Da-sein of Colorectal Cancer*?"

---

[147] Also see Appendix E.

It should be noted that in the results and discussion chapters, the term subject(s) will be replaced with the term patient(s).

"But I don't really want to crawl into a corner. I have to stay active. Doing nothing makes me nervous. As far as it is possible (I want to) do something." (S4)

5. Toward Authentic Dasein

Analysis utilising Colaizzi's method brought to light one core category that was identified as *The Omnipresence of Cancer*. Two sub-categories emerged through analysis to be constitutive of the core category. These are *Toward Authentic Dasein* and *Mapping Out The Future*. In this chapter *Toward Authentic Dasein* will be addressed with examples of statements from patients[148] of the study *The Da-sein of Colorectal Cancer*. The findings of the study will be discussed in view of Heidegger's Ontology of Dasein (1993a; 1996)[149]. Relevant literature[150] will be linked in for further substantiation of the results.

Toward Authentic Dasein describes patients' reactions to having received a diagnosis of colorectal cancer and what this means for their lives. *Toward Authentic Dasein* is reflected in the following constructs that were derived from data analysis:

- Uncertainty
- Transitoriness
- Locus of Control

These constructs are underpinned by basic State-of-mind[151], namely Anxiety[152] ["Angst"] (Heidegger, 1993a: 184ff; 1996: 228ff) and a mode of State-of-mind, namely Fear ["Furcht"] (Heidegger, 1993a: 140; 1996: 179). Fear and Anxiety are often reflected in the form of shock as the diagnosis, its implications and subsequent management are realised by the patient. These issues are subsumed in the construct Uncertainty. An outline of Heidegger's writings about Fear and Anxiety is

---

[148] The term 'subjects' will now be replaced by 'patients' for the remainder of this thesis.

[149] Consult chapter 2.

[150] See chapter 3.

[151] Refer back to section 2.2 in chapter 2.

[152] To differentiate better Heideggerian terms from ordinary meanings, capital letters will be used for Heideggerian Fear and Anxiety.

provided below[153]. With regard to the construct of Transitoriness the Existential Being-towards-death and Heidegger's perspective on death will be discussed[154]. The construct of Locus of Control will be elaborated by drawing on the Existential of the They[155]. In the following sections, the results of this study will be described as they appear in relation to the constructs of Uncertainty, Transitoriness and Locus of Control.

5.1. Heideggerian Fear And Anxiety

Fear is described as a mode of State-of-mind[156]. It exposes and illustrates Dasein's State-of-mind in an exemplary way (Heidegger, 1993a: 140ff; 1996: 179ff).

> "Fearing, as slumbering possibility of Being-in-the-world in a state-of-mind (we call this possibility 'fearfulness' ["Furchtsamkeit"]), has already disclosed the world, in that out of it something like the fearsome may come close." (Heidegger, 1993a: 141; 1996: 180).

Three main aspects of Fear are identified[157] (1993a: 140; 1996: 179). Firstly, there is an entity that Dasein fears, that is, the 'Fearsome'. Secondly, there is the fearing itself, and thirdly, that which Dasein fears for (Heidegger, 1993a: 140; 1996: 179). Dasein's Fear arises of any entity - be it present-at-hand, ready-to-hand or another Dasein - that exists in the world. Only an entity that exists in the world as present-at-hand, ready-to-hand or as Dasein-with may provoke Fear. Dasein perceives such an entity as a threat to itself.

> "That in the face of which we fear can be characterised as threatening." (Heidegger, 1993a: 140; 1996: 179).

---

[153] The introduction of Fear and Anxiety builds on chapter 2.
[154] Also consult chapter 2, section 2.7.
[155] Details about the They are in section 2.4 of chapter 2.
[156] Refer to section 2.2 in chapter 2.
[157] Compare to Mulhall (1996: 77ff).

There are at least six different aspects to such a threat. Common to all is Dasein's possibility of avoiding a direct contact with the threat (Heidegger, 1993a: 140; 1996: 179). It is possible, but not necessary, for Dasein to identify the entity that generates Fear[158].

The second aspect concerns feeling Fear as such. By feeling Fear, Dasein may discover what is threatening before it approaches (Heidegger, 1993a: 141; 1996: 180). The threat may manifest itself to Dasein through mounting feelings of Fear. Hence, the threat becomes available to Dasein for analysis and interpretation.

A third aspect of Fear is what Dasein fears for. Dasein mainly fears for itself (Heidegger, 1993a: 141; 1996: 180). This is possible on the grounds that Dasein is concerned about itself (Heidegger, 1993a: 141; 1996: 180). Through Fear, Dasein is disclosed as a Being thrown into the world. Fear discloses Dasein's Thrownness[159] (Heidegger, 1993a: 141; 1996: 180).

> "Fearing discloses this entity as endangered and abandoned to itself." (Heidegger, 1993a: 141; 1996: 180).

Although Dasein is primarily preoccupied with itself, it is possible to fear for another Dasein. It is an expression of Dasein's concern that refers to Dasein's outlook on life and the world[160]. Feeling Fear for another Dasein is grounded in the Existential Being-with and, therefore, is an existential mode (Heidegger, 1993a: 142; 1996: 181).

There are many modifications of Fear that may be of relevance to Dasein in everyday life. Fear may suddenly be imminent. Then it turns into Alarm. The reason of Fear may be completely unknown and unfamiliar. It may approach gradually. Fear arising from unfamiliarity is called Dread. If Dread is generated very suddenly by something, it turns into Terror (Heidegger, 1993a: 142; 1996: 181-182).

---

[158] Also refer to Luckner (1997: 64ff).

[159] Also see sections 2.2 and 2.6 in chapter 2.

[160] Consult section 2.2 in chapter 2.

> "All modifications of fear, as possibilities of having a state-of-mind, point to the fact that Dasein as Being-in-the-world is 'fearful' ["furchtsam"]." (Heidegger, 1993a: 142; 1996: 182).

Fear may also appear in the form of shyness and many lesser forms that are not explicitly stated (Heidegger, 1993a: 142; 1996: 181-182).

Anxiety refers to a particular way of Disclosure. In contrast to Fear, which is a mode of State-of-mind, Anxiety is a basic State-of-mind (Heidegger, 1993a: 184; 1996: 228). Although Fear and Anxiety are used interchangeably in everyday language, according to Heidegger, there is a profound difference between them (1993a: 185; 1996: 230). Anxiety is Disclosure grounded in Dasein's State-of-mind and Understanding. It provides insight about Dasein itself (Heidegger, 1993a: 184; 1996: 228). The importance of Anxiety for Dasein is demonstrated by the following statement:

> "Dasein's absorption in the "they" and its absorption in the 'world' of its concern, make manifest something like a fleeing of Dasein in the face of itself - of itself as an authentic potentiality-for-Being-its-Self." (Heidegger, 1993a: 184; 1996: 229).

In everyday life, Dasein is inauthentic and submerged in the They. In this instance, Inauthenticity is the choice over Authenticity, Dasein's ownmost Potentiality-for-Being[161]. This choice is illustrated by Anxiety. Dasein's characteristic of fleeing its Authenticity is made evident. There are two aspects to Anxiety. Firstly, there is that which gives rise to Anxiety in Dasein. This is characterised by being threatening and causing retreat.

> "That in the face of which one has anxiety [das Wovor der Angst] is Being-in-the-world as such." (Heidegger, 1993a: 186; 1996: 230).

Therefore, neither entities present-at-hand, ready-to-hand, nor other Dasein can give rise to Anxiety. It is Dasein as Being-in-the-world that primarily conditions Anxiety. Physiological factors impacting Dasein may also enable Anxiety (Heidegger, 1993a: 190; 1996: 234). In all, reasons for Anxiety remain vague and indistinct (Heidegger, 1993a: 186-187; 1996: 231).

> "Being-anxious discloses, primordially and directly, the world as world." (Heidegger, 1993a: 187; 1996: 232).

---

[161] Consult section 2.5 in chapter 2.

Besides that, which conditions Anxiety, there is also what Anxiety is about. This is closely linked with that, through which Anxiety arises, as it is one and the same, namely Being-in-the-world itself. Dasein is anxious of and about its Being-in-the-world itself (Heidegger, 1993a: 187; 1996: 232). Neither entities present-at-hand, ready-to-hand, nor other Dasein are significant in Anxiety anymore. Since they are no longer of importance, they are no longer visible. Dasein is brought before its Self through Anxiety and, therefore, before the very matter of what it is anxious about.

> "Anxiety individualizes Dasein for its ownmost Being-in-the-world, which as something that understands, projects itself essentially upon possibilities." (Heidegger, 1993a: 187; 1996: 232).

Because of Anxiety, Dasein is freed to consider and to choose its Authenticity, its unique possibilities. Dasein is no longer able to remain submerged in the They and its indifference. Through Anxiety, Dasein is confronted with its Self and thus becomes free for its ownmost Potentiality-for-Being. The familiarity of everydayness no longer exists. Anxiety is alienating (Heidegger, 1993a: 189; 1996: 233)[162].

There is a close connection between Fear and Anxiety. Fear is grounded in Anxiety. Fear is the inauthentic form of Anxiety.

> "And only because anxiety is always latent in Being-in-the-world, can such Being-in-the-world, as Being which is alongside the 'world' and which is concernful in its state-of-mind, ever be afraid. Fear is anxiety, fallen into the 'world', inauthentic, and, as such hidden from itself." (Heidegger, 1993a: 189; 1996: 234).

Dasein carries an awareness of its own finitude within. In everyday life, this awareness is not of importance. It is relegated to the back of the human being's mind (Heidegger, 1998: 12/12E)[163]. Thoughts of death emerge when another Dasein dies. In this instance, Dasein may have the opportunity to acknowledge the certainty of its own end. It is confronted with its own Self through Anxiety.

> "Being-towards-death is essentially anxiety." (Heidegger, 1993a: 266; 1996: 310).

---

[162] For further reading consult Gelven (1989: 114ff).

[163] Refer back to section 2.7 of chapter 2.

According to Heidegger (1993a: 190; 1996: 234) physiological factors may enable Anxiety in Dasein. The 'physiological factors' are not detailed. However, a congenital health problem, an illness situation or an accident are indicated by the choice of words. Health problems, therefore, condition Anxiety. Dasein's awareness of its own mortality is emphasised.

> "We may now summarize our characterisation of authentic Being-towards-death as we have projected it existentially: anticipation reveals to Dasein its lostness in the they-self, and brings it face to face with the possibility of being itself, primarily unsupported by concernful solicitude, but of being itself, rather, in an impassioned freedom towards death - a freedom which has been released from the illusions of the "they", and which is factical, certain of itself, and anxious." (Heidegger, 1993a: 266; 1996: 311).

Confronting death means becoming aware of human Transitoriness. This is perceived to be a motivation *Toward Authentic Dasein*. Realising one's Transitoriness means becoming free to make one's unique choices. Through confrontation with their Transitoriness, individuals are freed for their Authenticity. Individuals may be stimulated to change their outlook on life and on the world. Life may change for the better. Therefore, moving *Toward* a more *Authentic Dasein* may become a goal in people's lives.

5.2. Uncertainty

One of the three constructs that comprises the sub-category of *Toward Authentic Dasein* is Uncertainty. As will be demonstrated, patients suffer from Uncertainty grounded in implicit Fear and Anxiety, as they are described by Heidegger, (1993a: 140ff; 1993a: 184ff; 1996: 179ff; 1996: 228ff). Uncertainty initially grows from ignorance about patients' actual condition and gravity of their illness. Being given the diagnosis and having a suitable plan of action drawn up, serves to relieve some of the Uncertainty. However, uncertainties about the outcome of the disease and the effects of treatments are another source of Fear and Anxiety. During treatments patients experience long periods of waiting that intensify Uncertainty. Fear and Anxiety associated with Uncertainty break through and make it hard for them to cope with their situation.

Uncertainty arises as soon as patients notice a difference in their general well-being that is often as the first symptoms of the illness occur. Some patients experience blood loss when defecating; whereas other patients experience either unspecific feelings of weight and pressure in the pelvic area or pain when sitting or walking. Anything that disturbs their routine, and having stool changes, hints at problems in the intestines.

> S2: "I thought it would pass. As there was no improvement, I went to see the doctor. - I told him that I was having stool problems. Then the doctor sent me to a specialist for the stomach."
>
> S7: "One day I had diarrhoea with visible blood loss of which I informed the doctor."

Uncertainty is strong when interpreting the significance of unspecific changes in their bodies. Only the persistence of the symptoms that are accompanied by Uncertainty, are a motivation to consult a physician. Usually, patients go to see their family doctor. Consultation with the family doctor is the first step in a series of examinations that are expected to provide an accurate diagnosis of the patients' health problems. In four patients in this study the cause of the symptoms is not found at the first consultation. Examination results indicating that there is no problem are grasped gratefully and further tests are postponed.

> S6: "After the good examination results the doctor told me that he would still like to conduct a colonoscopy to really exclude all possibilities. The doctor pushed for a speedy date before my holiday. So did my husband and my daughter. But I didn't' want that before my holiday, as there was no time."

S6's statement implies an eagerness not to continue examinations at that moment. A planned holiday is used as an excuse. The statement provides insight about a potential dilemma. On the one hand, there is a serious health problem impairing the patient's well-being. On the other hand, the patient does not want the tests to continue at that moment as they may confirm the gravity of the health problem.

Out of the four patients in this study where nothing conclusive can be found in the first examination, three patients realise the significance of the changes in their well-being and bodies in the consultation with their family doctor. Therefore, patients direct their doctors to look again more closely. Despite the patients' realisation of the gravity of the situation, discovery of the illness first provokes feelings of surprise and astonishment.

> S1: "I was totally astonished. - Then I told my wife: You know, something is wrong."

Expressing astonishment and surprise at finding their well-being impaired hints at fears and anxieties that patients hold deep inside. Patients comprehend the importance and lasting effects of the bodily symptoms they encounter. Thereby Heidegger's Existentials State-of-mind and Understanding are introduced (1993a: 134ff; 1993a: 143; 1996: 175ff; 1996: 182)[164]. Symptoms of the disease provoke a range of feelings in patients such as fears and anxieties, astonishment and surprise. These feelings influence patients' assessment of the actual situation. Uncertainty arises and is reinforced. Patients' fears and anxieties further correspond with Heidegger's Fear (1993a: 140ff; 1996: 179ff). The illness is an entity present-at-hand that approaches and becomes evident to patients as symptoms. An approaching entity present-at-hand is described as provoking Fear according to Heidegger (1993a: 140; 1996: 179)[165]. However, according to Heidegger (1993a: 140ff; 1996: 179ff) the entitiy that calls forth Fear is not necessarily identified.

Patients realise the gravity of the situation and the potential threat to their lives. Extensive examinations provide results that physicians present to patients. Fear and Anxiety that underlie Uncertainty are substantiated by illness discovery.

---

[164] For more details refer back to sections 2.2 and 2.3 of chapter 2.

[165] Also refer back to section 5.1 in this chapter.

> S5: "I think the doctor was also surprised. - He also thought that it was tiny. Everybody had thought that it was tiny; despite all those machines."
>
> S6: "(During) the colonoscopy, I noticed that the doctor had difficulties inserting the instrument. The doctor then confirmed the necessity of an operation. I was shocked! But somehow I had known that something is wrong!"

In this instance, extensive examinations have provided a reason for the patients' deterioration in their well-being. Physiological problems have been identified, which may consitute a source for Anxiety (Heidegger, 1993a: 190; 1996: 234). Thus, Heideggerian Anxiety (1993a: 184ff; 1996: 228ff) can be linked with patients' anxieties. Patients' reactions to the reason for their health problems demonstrate the interrelationship between Fear and Anxiety. Firstly, there is the realisation of wrongness. Secondly, patients become aware of the impact of the health problem on their lives.

With the realisation of what the diagnosis of colorectal cancer means and what treatments will follow, Fear, Anxiety and Uncertainty deteriorate to depression and dejection. Patients experience intense sadness.

> S1: "I feel like a calf brought to slaughter. You don't know what they will do. You simply go there and hope for the best." (. . .) "Some of it is a kind of apathy."
>
> S6: "Naturally you feel a little bit down from time to time, but I was very, very sad."

Until the diagnosis of patients' health problems is confirmed and ready for disclosure, various amounts of time may elapse. It is possible that the cause of the health problems is not found immediately. Only further examinations will elicit the cause. Nevertheless, reasons for these periods of Uncertainty are speculated about. Patients discuss possibilities, such as difficulties in identifying the illness' symptoms.

> S7: "At first, everything went very slowly, then it happened very fast. One doctor, who did not know this kind of inflammation, made a statement that puzzled me. If you don't know it, you examine it, don't you?!"

For the patients these periods of Uncertainty are delays that can never be completely explained. Disclosure of the diagnosis is overwhelming and increases Uncertainty even more. Fear and Anxiety move to the forefront of patients' minds. Uncertainty arises early in the disease process, prior to having been told by physicians about the diagnosis of colorectal cancer and the examination phase.

Patients primarily experience sadness, Fear and Anxiety, culminating in Uncertainty when having received a diagnosis of colorectal cancer. They also experience overwhelming shock and terror at the extent of the cancer and its threat to their everyday lives.

Patients' experiences reflect State-of-mind as Fear (Heidegger, 1993a: 140ff; 1996: 179ff) and basic State-of-mind, namely Anxiety (Heidegger, 1993a: 184ff; 1996: 228ff)[166]. Initially, the illness is an entity present-at-hand existing within the world and approaching the individual. Thus, Fear arises in her. With the confirmation of the diagnosis a specific reason in the form of physiological factors is discerned for the patients' health problems. However, as colorectal cancer is a fatal disease, Fear of Dasein itself is generated that is defined as Anxiety by Heidegger (1993a: 184ff; 1996: 228ff). Patients are brought before themselves by becoming aware of the importance and impact of the disease on their lives. Although it is necessary to express caution with regard to linking Heidegger's Ontology of Dasein (1993a; 1996) and the findings of this study of *The Da-sein of Colorectal Cancer* that are of an ontic-empirical quality, correspondences between Heidegger's Ontology of Dasein (1993a; 1996) and patients' experiences when falling ill with a fatal disease can be identified.

As soon as the cancer is discovered and confirmed, speculation about its cause arises. There are notes and articles explaining the implications of healthy living, eating vegetables, not drinking, and not smoking. Patients come across such literature quite frequently. Either they are mailed leaflets by the Swiss Cancer League, or they find booklets lying around at the doctors' surgery. Magazines and newspa-

---

[166] Also refer to sections 2.2 of chapter 2 and 5.1 of this chapter.

pers also publish articles about cancer. Causes of and connections with the disease are particularly important to S5 throughout the study.

> S5: "'It' was discovered (on colonoscopy). - I was thunderstruck! And yet, I read the literature and am living such a healthy life! No alcohol, no cigarettes. I have never been ill. And now this terrible blow! That this can happen to me?! And I've never hurt anybody."
>
> S5: "If I could at least say that I did something (wrong)." (. . .) "Then I could at least see my fault." (. . .) "But I believe that it comes from my father's side."

Healthy living and good nutrition are S5's primary concerns. The reason for her suffering from colorectal cancer is incomprehensible to her, as she has always eaten a healthy diet. Having been diagnosed with colorectal cancer changes her world-view completely. Attempts to find a reason or cause - either somatic or spiritual - for the cancer is a way for patients to deal with their overwhelming Fear and Anxiety.

Subjective theorising about what causes the disease has been documented in the literature (Faller, 1998; Filipp, 1990; Filipp and Aymanns, 1997). It is recognised that patients who have received a diagnosis of cancer are concerned about its causes. Subjective theorising about causes is a way of attributing meaning to the disease that eventually results in a better understanding of the disease (Faller, 1998; Filipp and Aymanns, 1997). Therefore, subjective theorising is considered to be a coping mechanism that patients develop after having received a diagnosis of cancer. It ultimately promotes acceptance of the disease and supports the allocation of a place of its own in patients' lives (Faller, 1998; Filipp and Aymanns, 1997). Subjective theorising is also an expression of patients' beliefs that they are able to influence the disease process for the better. Healthcare professionals, as well as family and friends may support these attempts and ultimately promote the patients' coping mechanisms (Filipp and Aymanns, 1997: 3-5)[167]. In the literature, subjective theorising is not related to the factor of time. By contrast, patients in the study *The Da-sein of Colorectal Cancer* are primarily concerned about potential causes of the

---

[167] Refer to section 3.4 of chapter 3.

illness in the initial phase of the disease process. The interrelationship of time and subjective theorising offers a new and important insight into patient coping, which needs to be further explored.

All patients hear of cancer in some way or other and know about its outcomes. Television series or reports in glossy magazines describe grizzly and gory details about other people diagnosed with breast cancer, colorectal cancer, leukaemia or other forms of cancer. They hear from friends, family and others what might happen to a person diagnosed with cancer. Most patients hear or know of a family member, a neighbour or a friend who cannot tolerate chemotherapy or dies of cancer.

The prominence that patients give to cancer is a reflection of its increasing incidence, as well as of its place in society (Bain et al., 2002; Benner and Wrubel, 1997; Flanagan and Holmes, 2000; Martz, 1998; Reinacher-Schick and Schmiegel, 2002, Schulte, 2002)[168]. Cancer's primarily negative image in society reinforces patients' Uncertainty, as well as Fear and Anxiety.

Patients have to undergo surgical interventions, as well as treatment before and after. Usually, hospitalisation means long waiting times and loneliness that are an even worse experience when patients are alone in the hospital. They dislike these times intensely. They are identified as major sources of Fear and Anxiety.

> S2: "Waiting is the worst. Nothing happens." (. . .) "There isn't any information."

During waiting periods there is little distraction. Patients fall victim to vicious circles of thought that cannot be escaped. Uncertainty and its underlying Fear and Anxiety are reinforced. Patients have ample time to think.

> S2: "I still have the colostomy. Only when everything is over and healed well, in about three months or so, will the colostomy be replaced. Waiting again! Uncertainty again! That is really difficult to bear! I don't know if all will be well in the end."

---

[168] More details in section 3.4 of chapter 3.

> S3: "Now I will have to keep the ileostomy a little while longer. - It is so disheartening."
>
> S2: "I don't know if I will be able to just go on holiday, as I have to undergo further treatment."
>
> S2: "And I still don't know for sure how it will continue."

The difficult experience of waiting can be linked to Heidegger's notion of Waiting (1993a: 262; 1996: 306). It is closely associated with the Existential Understanding, and denotes the period between the projection of the future and its realisation. Therefore, future plans have already been drawn up.

> "To expect something possible is always to understand it and to 'have' it with regard to whether and when and how it will be actually present-at-hand. Expecting is not just an occasional looking-away from the possible to its possible actualisation, but it is essentially a waiting for that actualisation [ein Warten auf diese]." (Heidegger, 1993a: 262; 1996: 306)

Waiting involves suspense as the outcome of a situation is unknown from the individual's perspective. Heidegger (1993a: 262; 1996: 306) avoids attributing positive or negative opinions to Waiting. However, from the patients' point-of-view, waiting in hospital has a decidedly negative impact. It is linked with inaction that fosters repetitive thoughts and the impression of "no way out" (S2 and S4). Nevertheless, Heideggerian Waiting corresponds to waiting and loneliness, as patients also have plans for the future and are eager to realise them. Here, Heidegger's Ontology of Dasein (1993a; 1996) has provided insights into human reactions that have not been addressed before in the literature.

Only two patients receive pre-surgical chemotherapy or radiotherapy. After surgical intervention, five patients undergo radiotherapy as well as chemotherapy. Two patients submit to both treatments, others only chemotherapy. During the treatments patients wait for tests and interventions. Sometimes the patients' condition does not allow continuation of chemotherapy or radiotherapy.

> S3: "And then he said: we won't do it this week yet. We will start on Monday."
>
> S5: "And I have to wait another week, as my white blood cells are low."

Four patients were confronted with an ileostomy or colostomy. In three cases, the ileostomy or colostomy was temporary. For one patient the colostomy was for life. For all patients confrontation with the potentiality of a stoma is fearsome.

> S7: "I wasn't at all afraid of the operation. - What I feared most was the artificial outlet." (. . .) "So, when I woke up after the operation that was the first thing I checked. - I needed to know."

Stomas are initially perceived to be dirty and cause nausea. They are an outward sign of disease in the patients' bodies. Therefore, waiting until the definitive date of replacement of the stoma is known is difficult to endure.

Patients' experiences can also be linked with Temporality (Heidegger, 1993a: 323ff; 1996: 370ff)[169]. The disease develops over time. Its symptoms impact patients' everyday life, needing to be acknowledged. Fear and Anxiety are reinforced. Patients' anxieties correspond to Heideggerian Anxiety, in that they fear for themselves. In addition to fearing the disease, patients fear their own Being-in-the-world due to the life-threat that cancer poses. Therefore, patients' everyday life is disrupted and their outlook on the future challenged fundamentally. Patients' Understanding as it involves the projection of future possibilities is impacted by the Uncertainty generated by the disease. Fear and Anxiety underlying Uncertainty question patients' conceptualisations and visions. Literature emphasises the shock and deep fear provoked by a diagnosis of cancer (Faller, 1998: 20ff; Meerwein, 1998: 63ff; Senn and Glaus, 1998: 49ff)[170]. However, the pivotal role of Uncertainty as demonstrated by patients' statements and illustrated by using Heidegger's Ontology of Dasein as a frame of reference, has not been described explicitly in literature.

---

[169] See section 2.6 of chapter 2.

[170] Refer back to chapter 3, section 3.4.

5.3. Transitoriness

The second important construct comprised in the sub-category *Toward Authentic Dasein* is Transitoriness. As with Uncertainty, thoughts about Transitoriness reflect Heideggerian Fear and Anxiety (1993a: 140ff; 1993a: 184ff; 1996: 178ff; 1996: 228ff). Receiving a diagnosis of colorectal cancer provokes thoughts about death and dying and force patients to confront the finitude of their lives. These thoughts are seldom addressed explicitly by patients apart from accounts about others who are suffering from cancer. However, patients hint at their fear for life. Death becomes more of a possibility than life.

> S4: "I knew something was wrong. I didn't want 'my candle to be extinguished before Christmas'. After the festive period I was again admitted to hospital. The doctor showed me the pictures where a fungous mass was recognisable. The doctor told me that it was indeed something malignant."

Bodily changes and impaired well-being are evident for all patients. These changes are speculated about and keenly observed. At first, home-made treatments are applied and patients are eager to find improvement. Only after prolonged consideration do they feel the need for professional examination. At this point, patients realise that the illness symptoms have far more significance than they accord them.

> S6: "Yes, I knew something was wrong. I tried to treat it with remedies, but indeed I knew that I had to see the doctor."

Patients feel, even before the diagnosis is known, that something is wrong. Nevertheless, thorough examinations are postponed, although the significance of symptoms provokes concern. The interrelationship of symptoms and having hunches about a disease has not been explicated in the literature. However, patients' experiences demonstrate that having an idea about the gravity of an illness influences a person's disease management in the initial phases of the disease considerably. Further exploration of this connection is necessary[171].

---

[171] See section 6.2 of chapter 6 for further evidence about hunches.

A diagnosis of colorectal cancer can hardly be comprehended. It is overwhelming. Comprehension or acceptance of the diagnosis is not possible at first. Being given a diagnosis of colorectal cancer becomes a brutal interruption to patients' normal way of life. Everyday routine is no longer the same as there are numerous examinations to undergo. Colorectal cancer as a diagnosis means devastation[172].

> S3: "He showed me what was good: heart, lungs, liver. So I told him that he should tell me what is not good. He answered: your constipation isn't constipation. You have a malignant tumour." (. . .) "At home I cried for hours."
>
> S4: "In the tests there were no metastases. But there was a tumour in the intestine very close to the outlet. This information was a real blow. It was very hard to digest. The doctor told me directly (that) he saw in my eyes that I already knew what was wrong with me."

Although explicit statements are avoided, thoughts of death and the end of life are present in patients' minds. Confrontation with the extent of the cancer makes death a real potentiality that may happen any time. Confirmation of the patients' worst fears is a confrontation with their own Transitoriness. As a healthy person, mortality is a possibility that, nevertheless, is far away from the present. Death becomes the focus of thoughts and its potentiality turns into certainty. Realising the finitude of human existence is referred to in the literature with regard to the disclosure of a diagnosis of cancer and terminal stages of cancer[173]. It is reflected in patients' feeling shock and deep fear at the confrontation with a cancer diagnosis (Faller, 1998; Meerwein and Bräutigam, 1998). Coping with human Transitoriness and coming to terms with approaching death are predominant in the terminal phases of cancer (Faller, 1998; Kübler-Ross, 1996; Senn and Glaus, 1998). Patients' emphasis on the importance of Transitoriness from disclosure of the diagnosis of colorectal cancer onward throughout treatment and beyond is new and has not yet been explored in detail in the literature.

---

[172] Confer to section 3.4 of chapter 3.

[173] See section 3.4 in chapter 3.

Thoughts about death occur frequently. Usually, patients are alone and have to cope with it individually. It is believed, though, that others may help in such situations with support and comfort.

> S6: "There was one particular occasion where I felt terribly sad and devastated about the whole thing. - The nurse noticed immediately that I was sad and unhappy. She comforted me." (. . .) "I greatly appreciate a friendly face and genuine interest in my well-being in such difficult moments." (. . .) "When you are feeling so helpless and sad."

Although patients are informed about potential consequences of having cancer, they do not find this helpful. They feel threatened. Seeing other people in worse situations than patients are in themselves, and discussions between patients in similar circumstances increase Fear and Anxiety. Other patients' health situations give glimpses of their own potential future. The Transitory nature of life becomes evident to the patients.

> S5: "Cancer is well known to me. My friend died of cancer only a short while ago. She had only been ill for a short time and had suffered terribly. I was shocked by her illness and death."

Social support and its positive impact on patients diagnosed with fatal diseases have been considered in the literature (Faller, 1998; Leppin and Schwarzer, 1997; Meerwein and Bräutigam, 1998; Schröder, 1997)[174]. However, the negative influence of social support such as patients describe in this study has not been documented in the literature. In view of society's views about cancer, the impact of social support on patients with colorectal cancer needs further exploration[175].

The influence of other patients who suffer with cancer can be linked with Heidegger's Existentials the They, Being-with and Solicitude[176]. Dasein shares the world with other Dasein. It exists submerged in the They of everyday life. Due to the Existential Being-with, Dasein encounters, relates to and communicates with other

---

[174] Refer to section 3.4 in chapter 3.
[175] See section 5.4 for further evidence about support.
[176] Confer to 2.4 in chapter 2.

Dasein. The interrelationship between Dasein and others is one of Solicitude[177]. Therefore, a person is concerned about other people who are encountered in the world. It follows that individuals fear for other people (Heidegger; 1993a: 141-142; 1996: 180-181). Fear may arise in view of another person facing difficult or life-challenging situations. In such circumstances it is not necessary for the person experiencing a life-challenging situation to feel fear herself. Nevertheless, the observing individual may fear for the other person (Heidegger, 1993a: 141-142; 1996: 180-181). Patients' negative experiences at meeting other people in similar circumstances may therefore be explained.

In relation to the death of other Dasein, the They assumes a leading role. In everyday life, inauthentic Dasein aspires to coolness and detachment, i.e., to 'indifferent tranquility' ["gleichgültige Ruhe"] (Heidegger, 1993a: 254; 1996: 298), from personal involvement with regard to another Dasein's death. As part of the They, Dasein chooses to remain inauthentic and, therefore, does not want to be confronted authentically with its own Self and its finitude. Dasein may feel Fear about an entity present-at-hand approaching another Dasein (Heidegger, 1993a: 254; 1996: 298)[178]. However, fearing for another Dasein does not alleviate Fear (Heidegger, 1993a: 141; 1996: 181). In fact, the other Dasein does not need to be afraid at all. Fearing for other people is an expression of individuals being generally fearful and ultimately fearing for themselves (Heidegger, 1993a: 141-142; 1996: 181). Dasein's Fear for another according to Heidegger, therefore, corresponds with patients' Fear for other human beings in similar circumstances. However, Heideggerian Fear provides a deeper insight by pointing out that Fear for another Dasein is an expression of the underlying fearfulness of human beings.

Mortality becomes an important issue. Knowledge about cancer that means death is a very real possibility. None of the patients know whether they are going to survive

---

[177] Further details are to be found in section 2.4 of chapter 2.

[178] See also Gelven (1989: 150ff), King (2001: 153ff) and Luckner (1997: 103ff).

the treatments and interventions or not. Accounts by others patients suffering with cancer barely support the assumption that a diagnosis of cancer can be survived. Knowledge of impending death provokes Fear and Anxiety, as well as helplessness and loss of control[179]. Cancer becomes a burden and causes feelings of depression, dejection and apathy[180]. In particular, the sudden appearance of the disease and the inability of modern medicine to explain conclusively and exhaustively the origins of the cancer, are extremely difficult to accept. Only time takes the peak off abject Fear and Anxiety.

> S6: "There are now days when I don't have that flat panic that I suffered from in the beginning."

Fear and Anxiety remain present, even months after being told about having cancer and the conclusion of treatments. Any hint at cancer in a television programme or in a magazine resurrects Fear and Anxiety, thoughts about the end of life, as well as helplessness and loss of control.

> S3: "The fear is still there. That is clear." (. . .) "It is something new, after all." (. . .) "But I fear getting in to a bad state when I hear too much."
>
> S4: "When I started reading, I saw myself lying in bed and thinking . . . about dying. I was afraid."
>
> S3: "The reading of the texts was problematic. Programmes on TV are very difficult to watch. Also, being asked about my illness directly is still difficult at times. Then I get tears in my eyes immediately. I think of it and I am afraid."

When being presented with accounts of the patients' dialogues or reading something about cancer, the situation of being told about having colorectal cancer is brought to the forefront again. They relive difficult moments. Being confronted with the Transitory nature of their lives, means they develop a different outlook on life[181].

> S1: "You feel as if you are living a second time."

Confrontation with Transitoriness not only relates to Heidegger's notions of Fear (1993a: 140ff; 1996: 179ff), and Anxiety (1993a: 184ff; 1996: 228ff), but also the

---

[179] Will be addressed in detail in the section 5.3.
[180] See section 3.4 in chapter 3.
[181] Refer to section 3.4 in chapter 3.

two modes of Being - namely Authenticity and Inauthenticity - as well as the Existential Being-towards-death[182]. Heideggerian Fear explains to some extent the initial Uncertainty patients have when becoming aware of the importance of their symptoms. However, their fears turn into a more general fear for life as soon as the diagnosis of colorectal cancer is confirmed[183]. At this point, patients' experiences better correspond to Heideggerian Anxiety that describes Dasein's fear of Being-in-the-world as such. Hence, for Dasein to feel Anxiety, its existence must be threatened (Heidegger, 1993a: 186; 1996: 230-231). Heidegger (1993a: 190; 1996: 234) stated explicitly that Anxiety may be conditioned by physiological factors in individuals. Human existence becomes a threat, if its continuity is challenged by a fatal illness, for example, or being run down by a car. Fear is the inauthentic form of Anxiety and is therefore instrumental for inauthentic Dasein (Heidegger, 1993a: 254; 1996: 298). Anxiety, by contrast, represents Authenticity. It is an incentive for Dasein to consider its own Self. In view of approaching death constitutes a source for Anxiety. If Dasein is prepared to give in to Anxiety and to confront its own Transitoriness, it chooses Authenticity over Inauthenticity and therefore moves out from under the They's protective mantel. Being confronted with a diagnosis of colorectal cancer may offer an opportunity to encounter authentic Dasein. Authenticity relates to the individual's unique Potentiality-for-Being and is a dynamic state. Individuals want to realise the choices that are particular and unique to their lives. At any moment in life, people may choose to follow their unique possibilities and put them into effect. Individuals thus move *Toward* a more *Authentic Dasein*. Outlook on life and Being-with other people are influenced and changed. Authentic Dasein is the choice over inauthentic Dasein at that moment in life. However, the opposite may also happen, as well as a combination of both.

---

[182] For more details see sections 2.5 and 2.7 of chapter 2.
[183] Refer to sections 3.4 and 3.6 in chapter 3.

The profound changes a diagnosis of cancer may provoke in an individual's life have been described in the literature[184]. However, potential rationales for the changes have not been detailed. Drawing on Heidegger's Ontology of Dasein, an in-depth insight into human reaction is provided that reveals potential rationales for changes in a person's life.

According to patients' experiences, Fear and Anxiety exist together within the individual. Heidegger (1993a: 140ff; 1993a: 184ff; 1993a: 252ff; 1996: 179ff; 1996: 228ff; 1996: 296ff) did not indicate whether Fear and Anxiety may occur at the same time within Dasein. However, the emphasis on the dynamic and fluent state of Authenticity suggests that Fear and Anxiety may exist at the same time within Dasein. Patients' experiences represent the process of choosing Authenticity over Inauthenticity and vice-versa.

5.4. Locus of Control

A large aspect of having been diagnosed with colorectal cancer involves Locus of Control. The constructs Uncertainty and Transitoriness inform Locus of Control. When patients are healthy, they make their own decisions and live life accordingly. They exercise an internal Locus of Control. As soon as patients are told about their disease, Locus of Control shifts and thus becomes important. The discovery of the cancer and subsequent treatments often change how decisions are made. Patients' independence and dependence start to shift from internal to external Locus of Control[185]. Instability in Locus of Control occurs. With the first symptoms of the disease, and subsequent diagnosis of cancer, patients loose the ability to decide independ-

---

[184] Confer to section 3.4 in chapter 3.

[185] Refer to sections 3.3 and 3.4 in chapter 3.

ently about their lives. They accept decisions made by medical personnel about the procedure and treatments for cancer. The effects of an external Locus of Control that signifies that other people are in charge and make decisions are manifold.

> S1: "The doctor made an appointment for me for an examination in the outpatients."
>
> S5: "I am used to taking my life into my own hands. Nobody tells me to do anything. Since I have been ill, all has changed. I cannot make my own decisions anymore. Everything is given. That is very difficult to accept."

Locus of Control is documented as a factor in individual coping processes; whereas dependence and autonomy are factors associated with diagnosis and treatment (Faller, 1998; Filipp and Aymanns, 1997; Klauer and Filipp, 1997; Meerwein and Bräutigam, 1998; Schröder, 1997)[186]. There is evidence that cancer patients voluntarily, even deliberately, delegate decision-making to healthcare professionals (Faller, 1998; Meerwein, 1998). Delegation of Locus of Control to the medical care team is considered detrimental to patients' coping mechanisms (Meerwein, 1998). Therefore doctors and nurses should work with patients to help them to regain an internal Locus of Control[187].

Empathy and support by doctors and nurses are perceived to be expressions of their concern for the well-being of patients. Receiving empathy and verbal support are important to patients. Thus, they feel cared for. Empathy and verbal support by doctors and nurses enable patients to cope with the cancer. This is another manifestation of patients' delegation of the Locus of Control.

> S7: "When they presented me with the decision for surgery, I was quite happy."
>
> S1: "He (the doctor) informed me that he will do it so and that I don't need to be afraid of the operation."
>
> S7: "I found the discussion with the oncologist really positive. He (the oncologist) had told me that I was cured now."

Motivating statements by medical personnel help to develop courage to live through the situation. Information about a successful operation and confirmation that the

---

[186] Further reading in sections 3.2, 3.4 and 3.5 of chapter 3.

[187] Confer to sections 3.2, 3.5 and 3.6 in chapter 3.

cancerous tissue is removed signifies for patients that they have taken a major step towards regaining their health.

> S6: "My family doctor had told me prior to the surgery: Keep in mind that a complaint can be cured. And via the operation - if everything goes well - it is surely possible to remove the tumour. And that then is the cure. From that point-of-view, you might be able to manage the fear. That was very good for me. And that helped me a lot. Then I looked at the situation from that point of view."
>
> S7: "It was very helpful for me that the oncologist has spoken so openly to me." (. . .) "I don't think of the negative any more (that there might be cancer again), but instead I am looking forward to every day."

Motivation by doctors and nurses is particularly important after surgical interventions that confronted patients with an ileostomy or a colostomy. Patients need to adjust to their new body image[188].

> S3: "He (the doctor) told me that I have lived through many things already. That motivated me to accept this."
>
> S4: "The doctor told me that I shouldn't drive myself crazy with it (thoughts about the cancer)."
>
> S6: "The family doctor had also been concerned about it - that alone helped me. I didn't feel pushed aside."
>
> S6: "He (the doctor) had said that I should simply live, and I should be happy."

Patients' emphasis on verbal expressions of support by healthcare professionals offers another perspective to an external Locus of Control that has not been addressed hitherto in detail in the literature. Little et al. (1999) recognised the social and moral importance of approval and disapproval[189]. There is also evidence that Locus of Control is involved. However, patients feel that expressions of support foster their ability to cope.

Being given a diagnosis of colorectal cancer means that physicians must advise patients to take action against the disease. Healthcare professionals are quite open about the potential good that treatments will bring, but they are also honest about their ignorance in relation to the probability of completely eradicating cancer. Although doctors propose series of treatments, patients feel they do not really have a

---

[188] See section 3.4 in chapter 3.
[189] Refer to section 3.5 in chapter 3.

choice about either accepting or rejecting them. The physician's recommendations for treatment seem binding. Examinations are carried out. Patients think there is little they can decide for themselves. They are expected conscientiously to follow the recommendations given to them.

> S4: "The doctor strongly recommended I have the surgery done."
>
> S5: "They weren't sure whether I would need it. (They advised me to) have it done, although it isn't a guarantee for not having another relapse." (. . .) "I said, therefore, that I might as well wait and see?!" (. . .) "But they (the therapeutic team) didn't want to. So I went ahead."

Patients are also expected to accept treatments, such as chemotherapy or radiotherapy. Both treatments severely impact on patients' well-being due to negative side-effects. In addition, patients' everyday routine is disrupted as appointments for treatments are primarily arranged on a daily basis. The interrelatedness of delegation of decision-making processes and verbal expressions of support has yet to be explored[190].

Patients demonstrate an external Locus of Control when they accept the physician's recommendations for chemotherapy as is the case with S3. Chemotherapy is difficult to endure. It causes suffering.

> S3: "Without chemotherapy I am risking too much says the doctor. Because I was readmitted to the hospital for two weeks after the chemotherapy, I did not know what to do. I left the decision to the doctor."
>
> S7: "I mainly suffered from diarrhoea. That continued for some weeks until long after the conclusion of the chemotherapy."

In the case of additional health problems, such as cholecystolithiasis or abdominal influenza, side-effects of chemotherapy are pronounced. Activities of everyday life become severely limited. Patients feel constrained due to the overall effects of treatments. With an ileostomy or colostomy, activity is further limited. Stomas - i.e., ileostomy or colostomy - are completely new to patients[191].

> S5: "When I had the last cycle of chemotherapy, I couldn't go (out of the house). - (Because of the colostomy) I didn't dare!" (. . .) "At this moment,

---

[190] Confer to section 3.4 in chapter 3.

[191] Also see section 3.4 of chapter 3.

> I feel worse than directly after the operation." (. . .) "The colostomy is so dirty and its functioning so completely unpredictable."

Changes in Locus of Control become increasingly noticeable after hospital discharge and during therapeutic treatments - i.e., chemotherapy and radiotherapy. An external Locus of Control begins to be rejected, particularly in relation to the discontinuation of treatments. Although there is seldom any direct reference, patients indicate they "cannot break out."

> S5: "You cannot break out." (. . .) "It is impossible to avoid the therapies or to discontinue them. It would be your own fault then! After all, you have been informed! Then, it isn't their responsibility anymore! So, you just have to continue!"
>
> S5: "Again and again, I was confronted with a prolongation of the therapies. I asked myself and the doctors, if everything was all right." (. . .) "No, you can't do anything. You are forced. Dependent."

Not following medical advice, as S5 describes, is not accepted or supported by healthcare professionals. Discontinuation of treatments is only discussed openly when patients cannot tolerate it. Contrary to prevailing opinion that patients willingly and deliberately assume an external Locus of Control, patients identify institutional and medical reasons that support the transition from an internal to an external Locus of Control. The interrelatedness of the manifold impacts on patients' due to the diagnosis of colorectal cancer and Locus of Control as revealed by the patients in this study needs to be explored in more detail.

After conclusion of the treatments, screenings become necessary to monitor the patients' status. Screenings are perceived to be major sources of fear and uncertainty.

> S4: "The family doctor told me in the beginning that now there would be times when I would best like to simply cry my eyes out." (. . .) "There will also be uncertainties with every screening and examination. - You won't get a 100 % guarantee!"

Each screening resurrects fears about finding cancer. Past treatments are brought to the forefront once again, as well as questions about the length of patients' lives. They will never be 'free' of the disease again. Patients feel that cancer is in control of their lives.

> S5: "I don't know how I would react if there would be something else. That would be very hard for me to bear!"

The importance of screening as a source of Uncertainty and Fear and Anxiety, as well as its impact on Locus of Control has not been recorded in the literature. In addition, Locus of Control as such does not appear in Heidegger's Ontology of Dasein (1993a; 1996) that is primarily concerned to describe Dasein's Being in everyday life. The shift from an internal Locus of Control to an external Locus of Control , however, corresponds to Heidegger's descriptions of the two modes of Being, namely Authenticity and Inauthenticity. Delegating decision making processes to doctors and nurses is reminiscent of inauthentic Dasein living submerged in the They. Decisions and attitudes of the They are accepted without dispute. It can be argued that in everyday life patients live submerged in the They. Although, patients who have received a diagnosis of cancer find themselves in a special situation in which everyday life is disrupted, Heidegger's Ontology of Dasein (1993a; 1996), in particular the description of the two modes of Being, namely Authenticity and Inauthenticity, offers potential explanations for patients' delegation of an internal Locus of Control to the They who can be identified as the healthcare professionals. If a diagnosis of cancer constitutes a reason for considering authentic Dasein, then a person's unique and special possibilities become of interest. This corresponds to an internal Locus of Control that is not made evident in patients' experiences in *Toward Authentic Dasein*. With the confirmation of the diagnosis and the confrontation with the finitude of human existence, Anxiety arises, offering patients a glimpse of the possibility of Authenticity and therefore another way of making decisions. However, in order to cope, patients reject Authenticity and continue to live submerged in the They, accepting its decisions as their own. This process reflects Heidegger's (1998: 12/12E-13/13E) notion of 'being thrown back'.

> "Running ahead to the past is Dasein's running up against its most extreme possibility; and in so far as this 'running up against' is serious, Dasein in this running is thrown back upon itself as still Dasein." (Heidegger, 1998: 12/12E-13/13E).

An individual who is confronted with her finitude is 'running up against its most extreme possibility' (Heidegger, 1998: 12/12E-13/13E). Thus, the person glimpses her possibility for authentic Dasein. She is, then, brought before herself; i.e., 'thrown back upon itself as still Dasein' (Heidegger, 1998: 12/12E-13/13E). Nevertheless, Authenticity is not a state that, once achieved, remains forever. The human being who has had this chance, will return to inauthentic Dasein, as this primarily constitutes the kind of Being of everyday life. In talking with doctors and nurses about the cancer, patients are confronted with themselves. In addition, they discuss the disease with family and friends. Patients begin to evaluate their own place in life[192]. This invokes the notion of 'existential communication' that is discussed by Jaspers (1991: 375ff; 1991: 577ff)[193] and also by Heidegger (1993a: 155-157; 1993a: 162ff; 1996: 197-199; 1996: 205ff; 1998)[194]. According to Jaspers (1991: 370) communication is closely interrelated with thinking and recognising. In talking, thought processes are verbalised and thus become accessible for other human beings (Jaspers, 1991: 370)[195]. By communicating with each other, individuals not only disclose their thoughts to each other, they also make evident to one another, who they are, which provides them with the opportunity to become aware of and experience themselves, as well as the other (Jaspers, 1991: 372-373). Through communication with other humans is it possible for a person to relate to her actual world and her own concrete existence. More importantly, through communication, the individual's own unique Self arises (Jaspers, 1991: 374). Thus, a person is freed to choose her authentic Dasein (Jaspers, 1991: 371ff)[196]. From Heidegger's (1993a: 167ff; 1996: 210ff; 1998: 9/9E) perspective, Speaking[197] assumes a similar role. By Being-with others and Speaking with them, a person discloses her Being-in-the-world and,

---

[192] Confer to sections 3.4 and 3.6 of chapter 3.

[193] Further reading in section 3.1 of chapter 3.

[194] Refer back to chapter 2 and section 3.1 in chapter 3.

[195] Further reading in Hersch (1990: 92-93), Jaspers (2001: 21ff; 2001: 95ff) and Saner (1991: 100ff).

[196] Also check Kaufmann (1989: 172ff).

[197] See section 7.2.1 of chapter 7 for more details about Speaking.

therefore, is able to confront the Self (Heidegger,1998: 9/9E)[198]. However, it is up to the individual herself whether she accepts the choice to move *Toward Authentic Dasein* or to remain inauthentic Dasein. Whatever the decision, her Being-in-the-world, including her State-of-mind and Understanding will be impacted.

5.5. Toward Authentic Dasein - Summary

Being given a diagnosis of colorectal cancer throws patients into new situations. Patients are confronted with Uncertainty, Transitoriness and change in Locus of Control that are expressed as Fear and Anxiety. The interrelatedness of Uncertainty, Transitoriness and Locus of Control reveals the devastating impact of a cancer diagnosis on a person's life. Every preconception is challenged. Outlook on life changes. Support by others - i.e., family, friends, doctors and nurses - becomes very important to patients. Devastation then becomes manageable.

The impact of knowledge about death on the individual is described by Heidegger (1993a; 1996; 1998)[199]. Certainty of death may change an individual's outlook on life. It follows that Being-with other people in everyday life and the individual Being-in-the-world are also influenced and change may occur. By realising the certainty of death, a person may glimpse her authentic Dasein. The picture presented there might be so desirable that the person starts to work *Toward* the realisation of *Authentic Dasein*. However, an individual is free to choose to remain inauthentic and not to realise her Authenticity. The choice open to the individual is evident in the dialogue of patients, are elaborated in *Toward Authentic Dasein*.

---

[198] For further information see Luckner (1997: 71ff).

[199] Also consult section 2.7 in chapter 2.

In the chapter that follows, *Mapping Out The Future* will be described. *Mapping Out The Future* represents the patients' transition, regaining their Locus of Control and acceptance of *The Omnipresence of Cancer*.

"It is still difficult for me to accept the situation. - But I have to live with it. That's so. I have to accept the illness as it appears." (S5).

6. Mapping Out The Future

The sub-category *Mapping Out The Future* demonstrates the second dimension that comprises *The Omnipresence of Cancer. Mapping Out The Future* encompasses three constructs. These are:

- Uncertainty
- Transitoriness
- Locus of Control.

These constructs are interrelated as has been demonstrated in *Toward Authentic Dasein*. As in chapter five, parts of Heidegger's Ontology of Dasein (1993a; 1996) will be associated with the findings that are illustrated through the patients' statements. The second sub-category *Mapping Out The Future* encompasses patients' attempts to return to everyday life and to take up familiar and well-known routines. Whereas *Toward Authentic Dasein* primarily comprises patients' reactions to being diagnosed with colorectal cancer, *Mapping Out The Future* encompasses patients' coping mechanisms with the disease process. *Mapping Out The Future* can be linked with the Existential Understanding[200] (Heidegger, 1993a: 143ff; 1996: 182ff). Underlying the constructs Uncertainty, Transitoriness and Locus of Control that comprise the sub-category *Mapping Out The Future*, are issues associated with the routine of the human existence and possibilities for the future. Besides Heidegger's Existentials Understanding and Temporality, the two modes of Being - namely Authenticity and Inauthenticity - are of importance. Indirectly, the notions of 'Running ahead', 'Thrown back', 'Utter indeterminacy' and 'Levelling down' (Heidegger, 1998:

---

[200] See section 2.3 of chapter 2.

12/12Eff) play a role. They introduce Dasein's Being-towards-death[201]. The following passages incorporate these expressions and are therefore instrumental for comprehension.

> "In so far as Dasein is an entity that I am, and is simultaneously determined as being-with-one-another, it is not I myself who for the most part and on average am my Dasein, but the Others; I am with the Others, and the Others are likewise with the Others. No one is himself in everydayness. What someone is, and how he is, is nobody: no one and yet everyone with one another. Everyone is not himself. This Nobody by whom we ourselves are lived in everydayness is the 'One'. One says, one listens, one is in favour of something, one is concerned with something. In the obstinacy of the domination of this One there lie the possibilities of my Dasein, and out of this levelling-down the 'I am' is possible. An entity that is the possibility of the 'I am' is as such, for the most part, an entity that *one* is." (Heidegger, 1998: 8/8E-9/9E).

The They[202] determines everydayness so that the individual Dasein is relieved of deciding for itself. In everyday life, the They provides direction and therefore Dasein is relieved of responsibility. Dasein feels free of a burden[203]. Being part of the They means that Dasein exists submerged in the They. It is on one level with all other Dasein who are part of the They. Distinction is not necessary. However, out of the indistinctiveness of everydayness and of being part of the They, distinction becomes again a possibility for Dasein. Therefore, authentic Dasein is not possible without Dasein having lived submerged in the They, i.e., Inauthenticity. Hence, Dasein must level itself down and become part of the They for the possibility of authentic Dasein to be revealed. However, for Authenticity to become a potential choice for Dasein, an incentive is necessary.

> "What is it to have one's own death in each case? It is Dasein's running ahead to its past, to an extreme possibility of itself that stands before it in certainty and utter indeterminacy. Dasein as human life is primarily being possible, the Being of the possibility of its certain yet indeterminate past." (Heidegger, 1998: 12/12E).

Dasein's 'Running ahead to its past' (Heidegger, 1998: 12/12E) describes an individual's confrontation with her own death. At this point, death is a certainty. Never-

---

[201] See section 2.7 of chapter 2.

[202] For more details refer to sections 2.4 and 2.5 in chapter 2. See also Dreyfus (1995: 141ff).

[203] Confer to Heidegger (1993a: 127ff; 1996: 164ff).

theless, details about Dasein's own death, such as the when, where and how of death, remain indeterminate and vague. In addition, the reasons for Dasein to confront its own death are not specified by Heidegger (1993a: 249ff; 1996: 293ff). Because Dasein also is Being-towards-death[204] and has Anxiety[205] as basic State-of-mind, an incentive as such to confront death is already provided[206]. Physiological issues may condition Anxiety within an individual. Thus, a person is brought before herself, as Anxiety reflects Dasein being anxious of itself. Dasein is provoked to consider its own death (Heidegger, 1993a: 184ff; 1996: 228ff). Confrontation with her mortality constitutes a possibility for a person to glimpse her Authenticity[207]. Thus, the individual moves out from Inauthenticity and away from the They. It is, however, up to the person herself whether she grasps the possibility for Authenticity or not.

> "In so far as running ahead to this past maintains the past in its specific 'how', the 'how' of Dasein itself becomes visible. Running ahead to the past is Dasein's running up against its most extreme possibility; and in so far as this 'running up against' is serious, Dasein in this running is thrown back upon itself as still Dasein. This is Dasein's coming back to its everydayness which it still is, such that the past as authentic 'how' also uncovers everydayness in its 'how', takes it in its bustle and its busyness back into its 'how'. The past brings all 'what', all taking care of and making plans, back into the 'how'." (Heidegger, 1998: 12/12E-13/13E).

Contemplation of one's own death and coping with it reveals to Dasein its own Self and its life. Both are thrown into relief and can therefore be analysed. Thus, Dasein may consider change. 'Running ahead' up against Dasein's past ends in Dasein's bouncing back into the present. It is thrown back into everydayness. However, Dasein's new knowledge about itself and its life will take effect in everydayness. Authenticity will make a difference to Inauthenticity[208].

---

[204] Refer to section 2.7 in chapter 2.

[205] Details about Anxiety are to be found in section 5.1 in chapter 5.

[206] Further reading in Gelven (1989: 154ff).

[207] Also consult section 2.5 in chapter 2.

[208] Consult King (2001: 201ff), Luckner (1997: 125ff) and Solomon (1972: 210ff).

6.1. Uncertainty

Uncertainty in relation to the sub-category *Mapping Out The Future* encompasses issues associated with patients' coping with cancer and its treatments. In addition, Uncertainty in *Mapping Out The Future* involves the importance of other people in relation to the patients.

In the early stages of the disease process, family and friends assume an important role. Family and friends motivate patients to consult a doctor at the first symptoms of the disease.

> S6: "Nevertheless, the stool problems didn't improve. My husband and my daughter urged me to go to the doctor. After consideration, I followed their advice."

Due to the Uncertainty generated by the illness, patients draw on family and friends for direction. The importance of family and friends in the patients' disease process becomes increasingly important. Recent publications address the difficulties of families who are confronted with cancer when one of the family members has fallen ill[209]. The strain on the family is extremely high in the terminal stages of cancer (Faller, 1998; Meerwein and Bräutigam, 1998; Schwarz and Hornburg, 1994). Therefore, families of patients diagnosed with cancer also need support from the confirmation of diagnosis onward (Bluglass, 1991; Bürgin and Di Gallo, 1998; Holzer-Pruss, 2001; Leppin and Schwarzer, 1997). Apart from family and friends, healthcare professionals, including doctors, nurses and other proponents of medical specialist areas, assume key roles in patients' views and management of their disease[210]. The cancer provokes Uncertainty[211]. One major source of Uncertainty identified by patients is information provided by doctors and nurses regarding the disease and treatments. In hospital information is often sketchy and vague, thus increasing Un-

---

[209] See also sections 3.4, 3.5 and 3.6 in chapter 3.

[210] Compare with section 3.2 in chapter 3.

[211] See section 5.2 in chapter 5.

certainty - i.e., Fear and Anxiety - about procedures[212]. Uncertainties regarding timing and duration of post-operative treatments, such as chemotherapy and radiotherapy, prevent patients from knowing how life will work out.

> S5: "I still don't know exactly what is going to happen after I leave the hospital, as the results haven't arrived yet. I hope everything will be alright."

The amount and kind of information available to patients in the hospital environment has been a focus in research. It has been demonstrated that patients do not always receive the information they need (Galloway and Graydon, 1996). Lacking information prevents patients from coping successfully with the illness situation and return to everyday life and familiar situations. Therefore information needs to be available to patients at their request and according to their needs (Bain et al., 2002; Fallowfield et al., 2002; Glaus et al., 2002; Sahay et al., 2000)[213].

The disease and its treatments become the centre of patients' lives. Their ordinary existence can no longer be envisaged. Adjuvant treatments, such as chemotherapy and radiotherapy, impact everydayness. There are practical worries such as travelling from home to hospital to undergo chemotherapy and radiotherapy. One of the patients (S2) received chemotherapy and radiotherapy prior to surgical intervention. He lives quite a distance from Zurich where he had to undergo the treatments. Therefore he turned to healthcare professionals for help.

> S2: "I don't know how the chemotherapy will work out. I don't know how I can travel everyday from home to the hospital. But I hope that doctors and nurses will help me."

Medical personnel in hospitals are working under many constraints. Most noticeable to patients are constraints that prevent doctors and nurses from finding time for discussions about the patients' illness experience. Lack of time for open discussions about the diagnosis of cancer and its effects on life is very difficult for patients to accept. Incomplete information, provoking Uncertainty, impacts patients' emotional and physical well-being deeply. Limited information impairs patients' illness man-

---

[212] Consult section 3.3 of chapter 3.

[213] Refer to sections 3.2 and 3.3 in chapter 3.

agement. The expert knowledge of doctors and nurses given to patients supports coping with the disease process. Discussions between healthcare professionals and patients increase quality of care and treatments[214].

> S7: "I particularly valued when doctors and nurses had time to talk to me."
>
> S5: "I appreciate when they (doctors and nurses) have time to say hello during treatments."

The importance of expert knowledge for patients has been recognised and substantiated by literature (Bain et al., 2002; Little et al., 1999)[215]. However, time constraints and structural problems of healthcare institutions prevent the introduction of more in-depth discussions between the medical care team and patients (Morton, 1996). In addition, general social beliefs about cancer also influence healthcare professionals' views and attitudes (Flanagan and Holmes, 2000; Nettleton and Gustafsson, 2002; Pestalozzi, 2000; Senn and Glaus, 1998)[216]. As soon as patients are provided with more information about their condition, Uncertainty is reduced and patients can begin to plan for their future[217]. Similarly, information about the disease supports illness management and coping processes (Bain et al., 2002; Galloway and Graydon, 1996). Patients in this study, however, emphasised the importance of in-depth discussions with healthcare professionals, in which the illness experience can be described and analysed. In addition, patients welcomed expressions of empathy by healthcare professionals.

> S5: "Nothing has been found. The doctor in the chemotherapy suite told me that it is only prophylactic." (. . .) "The same applies to the radiotherapy. It is necessary because there are metastases of the tumour already. With the chemotherapy and radiotherapy, possible malignant growth elsewhere in my body is treated. So nothing is overlooked. This procedure reassures me."
>
> S7: "I have talked with the oncologist (in hospital). The discussion was very fruitful and very positive." (. . .) "The oncologist told me that I am cured now, as the tumour has been removed and nothing was found in the immediate area."

---

[214] Compare with section 3.2 in chapter 3.
[215] See section 3.5 in chapter 3.
[216] Refer to sections 3.2 and 3.4 of chapter 3.
[217] Consult section 3.3 in chapter 3.

Information and discussions clarify the disease process and support coping. They enhance critical reflection and analysis of the disease process. Thus, patients are better able to conceptualise their illness situation and to look to the future. New projections about the future can be made. Everyday life becomes manageable again. Expressions of interest and empathy offered by healthcare professionals assume a similar position. Patients value personal comments by doctors and nurses about the disease process and the cancer, as they reinforce positive attitudes and facilitate coping[218].

> S1: "They (healthcare professionals) told me that they will try to carry out the intervention via the colon. That was very comforting for me."
>
> S4: "The family doctor and the surgeon confirmed that the situation is well in hand with CT (computerised tomography), blood tests and sonography. This reassured me greatly and helped me to cope with the illness."

Clearer information becomes a basis for comfort and improves illness management. Expert advice and contentment with the illness situation expressed by medical personnel counter patients' Uncertainty and are reassuring. Conceptualising the future and return to everyday life is facilitated[219]. Going home and functioning in familiar roles again is seen as possible, as well as taking up hobbies. The extent of the positive effect of healthcare professionals' expressions of consideration towards patients has not been substantiated to any extent in the literature. It is solely recognised that it has an impact - either positive or negative - on patients' disease management (Bain et al., 2002; Little et al., 1999; Morton, 1996)[220].

After the conclusion of the anti-cancer treatments, patients must undergo regular screenings[221]. These examinations are perceived to be highly stressful until results are known. Patients are aware - from the confirmation of the diagnosis onward - that malignant growth may recur despite treatments. Therefore, screenings are sources of Uncertainty.

---

[218] Refer to section 3.5 in chapter 3 for more details.

[219] See section 3.5 of chapter 3.

[220] More information in section 3.6 of chapter 3. Also refer to Appendix G.

[221] Compare to section 5.2 in chapter 5.

> S4: "I am tense at each screening, as I don't know how the results will be. And now I know what will happen, should something be found. Before the illness is discovered, I didn't really know what was going to happen, but at least, now I know and can plan."
>
> S4: "At each screening I am again confronted with the illness. There is this uncertainty." (. . .) "Even good (screening) results are no guarantee."

Screenings move the cancer to the forefront of patients' minds. The past months are relived in memory. All experiences are present again. At this stage the procedure of anti-cancer therapy treatments is well-known. The suspense before the screening results are published is difficult to endure and to cope with. Uncertainty is reinforced. The impact of screenings as a major source of Uncertainty has been newly revealed in this study. Patients indicate that the Uncertainty experienced prior to and during screenings, until results are known, is reminiscent of the period prior to the confirmation of the diagnosis. Everyday routine is once more disrupted and life put on hold[222].

Good screening results are a sharp contrast to the state of limbo and suspense between screenings and publications of results. Patients feel overpowering relief and a source of euphoria and happiness. They are reassured to move forward with their lives.

> S4: "The last screening results have been very good indeed. I and my doctor almost danced with joy." (. . .) "Now I am really happy and can make plans for my holiday."
>
> S5: "Now I am happy that the screening results are alright. I can look ahead."

Uncertainty is temporarily relieved. For the time being, patients are offered a confirmation that no further malignant growth was detected. Nevertheless, Uncertainty arises again at the next screening. In between the examinations, Uncertainty moves to the back of patients' minds. Therefore, patients are alternating between periods of high Uncertainty and time-spans with higher certainty. However, they are never again completely certain about their health[223]. Uncertainty about the future of pa-

---

[222] Refer to Appendix G.
[223] This will be highlighted in chapter 7.

tients who have been diagnosed with cancer has been addressed in the literature (Black and Hyde, 2002; Galloway and Graydon, 1996; Mishel, 1981). However, patients in this study emphasise that Uncertainty will remain with them. The impact of Uncertainty and its lasting nature have not been explicated in the literature.

Nevertheless, patients need to develop strategies to cope with Uncertainty in relation to screenings. For some patients it is helpful deliberately to put thoughts about the disease out of their minds in the screening-free periods. Continuous thinking about the illness is destructive. Patients feel low and dejected when they think about the cancer. It is like a "vicious circle" (S2) that is difficult to escape. They try to forget cancer.

> S1: "I think about it, but then I put these thoughts away."
>
> S2: "In general, I am able to forget the illness quite easily, but it does come back."
>
> S2: "I won't think of 'it'. There are days when I am fine. Then, thoughts about the illness are not in the forefront (of my mind). But on other days it is like a vicious circle. Thinking about 'it' is not helpful."
>
> S3: "And I don't want to think about 'it' too much. It hurts me to think about 'it' and makes me nervous." (. . .) "When I think about 'it', I start crying. And that weakens me."

Not thinking about the cancer is perceived to be more helpful in dealing with the fatal illness. A similar coping strategy is the avoidance of using the term cancer. Patients are either unable to remember the medically correct term for their disease, or they refuse to call it cancer altogether. Other terms are used instead.

> S1: "There was never any talk of cancer. 'It' was called malignant polyp."
>
> S4: "I am quite unable to say cancer. I have a tumour! I don't have cancer! - Tumour sounds nicer! - Cancer is something definite! - I can't say it!" (. . .) "If they ask me, I say: yes, I have a tumour!"
>
> S1: "I don't want to know anything about it." (. . .) "I have had enough! I can't watch it here. It is uncomfortable."

Patients also avoid watching TV programmes about cancer. These coping strategies are their way of distancing themselves from the illness situation. Patients thus lay their thoughts to rest. The disease is no longer the most important issue in their lives. Cancer thus becomes manageable.

> S5: "I just have to let go. - Letting go isn't forgetting. It is more like standing beside oneself and watching. This way I can bear the situation."

Other strategies are not talking or reading about the cancer. As S2 explains, talking about the disease increases a person's worries.

> S1: "I don't want to know anything about it anymore."
>
> S6: "I don't want to talk about it all the time."

Reading about the disease has a similar effect and therefore is avoided. Cancer becomes ever-present and thus assumes priority in patients' lives. All these strategies are forms of denial and, therefore, involve suppression of feelings (Klauer and Filipp, 1997: 385ff; Kübler-Ross, 1996). These strategies have been thoroughly described and researched (Faller, 1998; Schwarz and Hornburg, 1994; Schwarzer, 1997). In phase-models such as the one put forward by Kübler-Ross (1996) strategies of denial form a necessary part in the coping process[224]. However, it is suggested that denial is not the most ideal way of coping with cancer, as it does not involve a thorough process of considering the disease and its effect on the individual's life. Therefore the person risks being confronted with suppressed thoughts and feelings at a later date (Klauer and Filipp, 1997:394-395). Within the coping process, time is recognised as a crucial factor, determining the impact - either positive or negative - on patients' disease process (Faller, 1998; Klauer and Filipp, 1997). Therefore tactics of denial and avoidance are recognised as having a beneficial effect in the initial phases of the disease; notably incur social support (Klauer and Filipp, 1997). However, conclusive findings are lacking.

The above corresponds to Dasein's two modes of Being, namely Authenticity and Inauthenticity (Heidegger, 1993a: 53; 1996: 78)[225]. The two modes of Being are an individual's choice, according to Heidegger (1993a: 53; 1996: 78). As part of the They, denial is a legitimate strategy particularly regarding people's attitude to-

---

[224] Refer to section 3.5 of chapter 3.

[225] See section 2.5 in chapter 2.

wards their own mortality (Heidegger, 1998: 12/12E)[226]. Patients' use of denial in turn takes up Heideggers' notion of inauthentic existence. By not thinking about the disease, and avoiding to talk or read about cancer, thoughts about impending death are denied. In contrast, patients think about the Transitory nature of their lives at other stages in the disease process[227].

Patients also rely on their innate positive attitude towards life. A positive attitude reflects hope (Benzein and Saveman, 1998; Bühlmann, 2001), and also introduces the coping strategy dispositional optimism (Schröder, 1997: 321)[228], which is defined as a generalised expectation of good outcomes in an actual difficult situation generated by a disease such as cancer. Therefore, dispositional optimism corresponds with the concept of hope[229]. Belief in a positive outcome, coupled with hope, become important coping strategies for patients. Although the mechanisms of dispositional optimism have not been studied in-depth, its importance for patients' coping process has been recognised (Schröder, 1997: 321). Because of positive beliefs and hope, patients are able to hold Uncertainty at bay throughout the disease process. Patients draw on a positive outlook and on hope to find motivation to continue treatments and conceptualise their future lives.

> S6: "I overcame my uncertainties by drawing on a basically positive attitude."
>
> S2: "I keep telling myself that it will be as it should be."
>
> S4: "Now, I will wait and see what is going to happen. I am hoping."

Besides hope, patients also experience resignation about their illness situation. Thus, they are able to develop acceptance of the illness. Although the term 'resignation' hints at forced acceptance[230], patients avoid qualifying their acceptance, thereby lifting it to a level where it becomes an important coping strategy. Simi-

---

[226] Further reading in Gelven (1989: 150ff).
[227] Consult sections 5.3 in chapter 5 and 6.2 in chapter 6.
[228] See sections 3.4 and 3.5 in chapter 3.
[229] Confer with section 3.4 and 3.5 of chapter 3.
[230] Refer to section 3.4 in chapter 3.

larly, the overall rapid rate of events in the disease process such as further investigations and treatments is seen as being supportive and makes it easier to cope. All coping strategies, namely denial, positive attitudes, hope, resignation, acceptance and the rapid rate of events, are useful in developing an adapted outlook on life and the future. Coping also involves accepting the fact that the cancer remains a driving force in patients' lives, finding expression in patients' Uncertainty, manifesting itself especially around the time of regular screenings. Patients who have been diagnosed with cancer aim at adapting their lives to the new conditions generated by the disease. As cancer is a life-threat, the integration of the disease into life is an existential upheaval. Not only the actual situation changes, but future plans are fundamentally challenged (Klauer and Filipp, 1997: 396-398).

Patients' experiences can be linked to Heidegger's Existentials Understanding and the They[231]. Tightly interconnected, as the ontic illustration by the patients has demonstrated, are the two modes of Being, namely Authenticity and Inauthenticity. An individual lives life according to possibilities that she draws up and projects in her life. These possibilities are either unique to each person in authentic existence or can be those of the They and therefore of a more average kind in inauthentic existence. With a diagnosis of colorectal cancer, patients' inauthentic existence of the everyday, along with their ideas and conceptualisation of their future lives, are challenged. A cancer diagnosis signifies confrontation with the finitude of human existence. Impending demise becomes an issue of consideration. Therefore people diagnosed with colorectal cancer are confronted with their own mortality. In the sub-category *Mapping Out The Future,* previous plans are questioned and are adapted to the current situation. Reconsideration of life's conceptualisations and a brush with death offer opportunities to reflect on the inauthentic existence in everyday life. Patients have the opportunity to consider Authenticity. Therefore they

---

[231] Refer back to chapter 2, sections 2.3 and 2.4.

are presented with a choice of inauthentic or authentic Dasein, or something in between (Heidegger, 1993a: 53; 1996: 78; 1998: 13/13E)[232]. Inauthenticity can now be evaluated against Authenticity. As such individuals' unique possibilities emerge and are open for realisation, if they so choose. An individual's Understanding is modified and *Mapping Out The Future* is once more possible. The changes in the actual situation, in which a person finds herself, therefore, leads to modification and adaptation of her outlook on life and future ideas. Verbal support and expressions of empathy by the medical care team support the patients' coping process. Being-with others and communicating with them influences an individual's Understanding. In Speaking, people express their Being-in-the-world to each other, discovering and furthering authentic Dasein or reinforcing Inauthenticity. Hence, patients' high estimation of communication with healthcare professionals can be explained as their (patients') way of reflecting their Understanding[233]. Patients' coping strategies in managing Uncertainty generated by the disease represent their glimpse of authentic Dasein that enables them to reconsider and *Map Out* a new *Future*.

6.2. Transitoriness

As opposed to the construct Transitoriness in the sub-category *Toward Authentic Dasein*, Transitoriness in *Mapping Out The Future* comprises the reactions by family and friends at the confrontation with the finitude of human existence, as well as patients' strategies to cope with potential death.

Communicating the diagnosis to family and friends is very difficult for patients. They realise that the diagnosis and its implications on their lives may become a bur-

---

[232] Further reading in King (2001: 40ff).
[233] Also refer to section 3.1 in chapter 3.

den for family and friends. Therefore patients postponed telling family and friends about the diagnosis as long as possible.

> S6: "In the beginning, I didn't want to burden my children with 'it'. I didn't want to scare them. - I only told my eldest daughter as she is a medical laboratory assistant."
>
> S6: "I felt reluctant to talk with my family about 'it', as I know that it is also difficult for them and could be worse later on."

Introducing a fatal diagnosis into the family environment is problematic (Black and Hyde, 2002; Faller, 1998; Meerwein, 1998: 121; Northouse et al., 2000). Therefore, disclosure of the diagnosis needs to happen by taking the patient and her relationship with the family, as well as the family into account (Black and Hyde, 2002; Bluglass, 1991; Meerwein, 1998). Thus, patients' coping processes are fostered and artificial obstacles related to information deficits can be avoided (Bürgin and Di Gallo, 1998; Holzer-Pruss, 2001)[234]. At some stage in the disease process, telling family and friends can no longer be avoided. Patients maintain, however, that they need to come to terms with the diagnosis themselves before they are able to inform their family and friends.

> S5: "I couldn't talk with my family at first. I wanted to spare them."
>
> S6: "I have told my family now. When I was about to have the colonoscopy, I felt I had to tell them as I thought something momentous would happen." (. . .) "However, I had to come to terms with 'it' myself before I was able to talk with my family."

The importance of families and friends for patients diagnosed with a fatal illness has been recognised in the literature. There is evidence that informing family and friends about the diagnosis is difficult for those concerned (Black and Hyde, 2002; Faller, 1998: 67). In addition, gender is perceived as influencing the way information is provided within families or to friends (Northouse et al., 2000; Schröder, 1997: 339). Not only is it problematic to tell the diagnosis to family and friends, but so is talking about potential demise. Family and friends are not eager to consider the patients' death. It is difficult to conceptualise.

---

[234] Consult sections 3.4 and 3.6 of chapter 3.

> S5: "My family says that I will be alright again soon. They don't believe that I might die from 'it'." (. . .) "However, it is important that everything is in order should something happen to me. My husband will have to learn the things he doesn't know."

Because they are confronted with their mortality in relation to *Mapping Out The Future*, patients want to put their affairs in order. Discussions occur about legal settlements and last will, but they do not assume a priority. Instead, practical arrangements are in the forefront of patients' minds as the statement above suggests. Patients evaluate the need for information that family and friends might need in case they die. Husbands need to learn about housekeeping, for example. At the same time patients are clear that they do not "want pity" (S6) when talking about their disease. Such arrangements contribute to successful coping with the disease (Northouse et al., 2000).

Apart from the controversy about giving information to family and friends, their support of the patients is generous and ever-present. They offer physical support such as transportation to hospital for chemotherapy or radiotherapy sessions. By their mere presence they provide comfort and security to the patients. Family and friends provide meaningfulness and something to hold on to. Their support is vital for patients to cope successfully with the cancer[235].

> S2: "I can't imagine going through 'it' on my own. Support is so very important."
>
> S4: "I have to go through it on my own. But it is different, when there is somebody else there. If I were quite on my own, I wouldn't know what to do. I couldn't imagine it."
>
> S6: "I was so lucky to have such a wonderful family!"

Social support has been researched for its impact on coping processes (Leppin and Schwarzer, 1997). It has been demonstrated that social support is crucial for patients diagnosed with fatal illnesses in order to manage successfully the stress generated by the disease (Leppin and Schwarzer, 1997: 356). However, the emotional

---

[235] Consult section 3.4 in chapter 3.

support patients experience from their families has not been described as detailed as in this study[236].

Although patients experience many difficulties and obstacles with colorectal cancer, the disease provides an opportunity to grow closer to family and friends. All become involved in the patients' disease management; thus opening new dimensions in their relationships. Situations arise in which all are able to express their feelings and emotions.

> S1: "I simply feel more drawn to my wife, because I would have been totally on my own without her. That would have been awful!"
>
> S7: "I was very well supported by my wife indeed. There were moments when I was thinking and worrying about 'it'. But she was always there for me."

Cancer changes patients' relationships with loved ones, family members and friends, making the relationships more intense and rewarding. Closeness is felt and welcomed. Cancer has been recognised as impacting patients as well as their families and friends, unlike any other disease (Meerwein, 1998: 121). Therefore it is crucial for healthcare professionals to speak with and support patients and their families, in order to promote successful management of the disease process (Faller, 1998; Leppin and Schwarzer, 1997; Meerwein, 1998). Recent endeavours in family model development demonstrate the crucial role families and friends play for patients with fatal diseases such as cancer or AIDS (Bluglass, 1991; Faller, 1998; Friedemann, 1992; Meerwein and Bräutigam, 1998).

A diagnosis of colorectal cancer introduces the finitude of human existence into everyday life[237]. Not only patients themselves are confronted with their mortality, but so are their families and friends. This raises issues regarding the Existentials Being-with and Solicitude[238]. Confrontation with death[239] impacts individuals' Being-with other people. A diagnosis of cancer illuminates interrelationships of human

---

[236] Also consult Appendix G.

[237] Consult section 5.3 in chapter 5.

[238] Details are to be found in sections 2.1 and 2.4 of chapter 2.

[239] This has been illustrated in sections 5.3 and 5.4 of chapter 5.

beings. Individuals have the opportunity to consider their Dasein and become aware of inauthentic, as well as authentic Dasein[240]. Confrontation with the finitude of human existence serves as a trigger for the reconsideration of individual Dasein, as Heidegger (1993a: 243ff; 1996: 287ff) has indicated[241]. Ultimately, through an individual's Understanding outlook on life is subjected to change. Issues regarding outlook on future life are reconsidered and adapted, if necessary. For patients and the family adaptation and the impact of change on Understanding becomes evident in their intensified relationships.

As awareness of human finitude impacts individuals' perceptions and life, it becomes necessary to cope with the knowledge of having been diagnosed with a fatal disease. For all patients, the diagnosis of colorectal cancer comes as a dilemma.

> S2: "On the one hand, I can't continue to live without an operation. On the other hand, I can't continue living as it is now." (. . .) "So I went through with the operation."

Should patients agree to treatments? Which should it be? What will happen afterwards? The diagnosis of colorectal cancer challenges pre-conceptions about the patients' future, as death is no longer only a remote possibility. It may occur sooner than previously expected. Future possibilities and ideas that were conceptualised have to be reconsidered and adapted to the actual situation. However, coming to terms with mortality is difficult from the patients' point of view. Various strategies are developed to manage the illness situation. Cancer is regarded as the patients' enemy. They have to fight against it[242]. Fighting cancer is energy-consuming, but also a way of building up motivation to overcome the illness in relation to *Mapping Out* their *Future*.

> S2: "It has been really difficult. Sometimes I could hardly go on. Fighting is using up a lot of energy. - But I will continue. I have made my decision. I want to live."

---

[240] Further reading in Gelven (1989: 140ff) and King (2001: 40ff).
[241] See sections 2.5 and 2.7 in chapter 2. Also consult King (2001: 150ff).
[242] Consult section 3.5 in chapter 3.

In relation to Transitoriness, talking about the illness experience is a coping strategy developed by patients. Being given a platform to discuss their illness situation such as in this study *The Da-sein of Colorectal Cancer* promoted some coping and acceptance of the disease. However, as was found in this study, discussion of the illness experience ceases to be supportive toward the conclusion of the treatments.

> S6: "You get to a phase, when you don't want to talk about 'it' any more, because it moves the illness to the centre. This is quite a struggle. You want to distance yourself then. So you can get on with life. "
>
> S7: "It is over for me now and I am not thinking about 'it' anymore. 'It' is like a task that has been completed."

Development of positive outlook and reinforcing the will to live are reflections of patients' hope that they will overcome the disease or find a way to live with it[243].

> S2: "I feel much better. There are no problems at the moment." (. . .) "Everything will be alright."
>
> S4: "I was very lucky. Everything is alright and I feel well again."

Thus, future life can again be envisioned. The interrelatedness of all coping strategies as described by the patients in this study has not yet been addressed in the literature and needs further exploration. It combines individual tactics into a meaningful process. Thus denial and avoidance become necessary components of successful coping processes. Nevertheless, surviving cancer is an individual experience. Despite open support and love from family and friends, patients have to live through the disease process on their own. Having survived a diagnosis of cancer, results in acceptance of the disease[244]. Cancer is allocated a particular place in patients' lives. It becomes a part of their life and, therefore, looking to future is possible again.

> S2: "I just have to go through with it. That is the best. There is no other way. And hope for the best as time passes."
>
> S4: "Despite family and friends you are alone. You have to deal with it on your own."

---

[243] See section 3.4 of chapter 3.

[244] Compare to section 3.5 in chapter 3.

The coping strategies developed by patients in this study have also been described in the literature (Kübler-Ross, 1996; Meerwein, 1998). Successful coping with a fatal illness results in accepting the disease and allocating it a place (Klauer and Filipp, 1997; Schröder, 1997)[245]. However, the emphasis on patients dealing with the illness on their own in the coping process offers a new perspective of the processes set in motion by the diagnosis of colorectal cancer.

Time also plays an important role in successful coping as it relates to the patients' realisation of their Transitoriness. Patients submit to examinations and treatments. The rapidity of tests and treatments does not allow much time for thinking. Therefore, some patients experience little time to feel Fear and Anxiety[246].

> S4: "There was hardly any time at all to be much afraid of things. Everything had happened very fast." (. . .) "In between there hardly had been any time to think about what was going to happen. This was very good."

Literature emphasises the passing of time as having an impact on patients' perceptions of the illness situation. As time passes, patients employ coping strategies that result in a gradual relegation of the illness to a particular time and place in patients' lives (Faller, 1998). Drawing on Senn and Glaus (1998)[247], the passing of time corresponds to patients' growing maturity and increasing capability of allocating the disease a place in their lives that is less formidable.

Successful coping culminates in acceptance of the illness situation and achieving resignation. Acceptance is based on the assumption that there will be an end to the limited range of activities caused by anti-cancer treatments.

> S5: "It is still difficult for me to accept the situation. - But you have to live with it. That is a fact. Take the illness as it comes."
>
> S1: "Yes, I just accepted it as it came."

---

[245] Compare to section 3.5 in chapter 3.

[246] Also consult section 5.1 in chapter 5.

[247] Refer to section 3.5 of chapter 3.

Patients demonstrate that awareness of human mortality impacts life severely. Confrontation with the knowledge of death cannot be avoided and coping strategies need to be developed. Dealing with awareness of Transitoriness can be linked to Dasein's possibilities for Authenticity and Inauthenticity[248]. In addition, Dasein's projective Disclosure that is Understanding is involved[249]. Patients' everyday routine is disrupted by the diagnosis of cancer. In their attempt to return to familiarity, they are forced to face the threat and find a method to either leave it behind or integrate it into their lives. Whatever their choice, they manage to cope with the illness and are able to *Map Out* their *Future*. Temporality is accepted[250]. Through the passage of time, reflection about Being-in-the-world[251] happens. Thus, people become able to evaluate the present by drawing on the past. Patients' outlook on the future is based on change and modification over time. This becomes part of the process in *Mapping Out The Future*.

6.3. Locus of Control

The final construct in the sub-category *Mapping Out The Future*, is Locus of Control. Patients talk about 'dependence, independence, and letting go'. These expressions are reflected in the literature by terms such as dependence versus autonomy (Meerwein, 1998: 106) or Locus of Control (Filipp and Aymanns, 1997: 10)[252]. Subsequently, the patients' regaining an internal Locus of Control and its impact on their coping process evolves as it relates to *Mapping Out The Future*.

---

[248] More details are to be found in section 2.5 of chapter 2.

[249] Compare to section 2.2 in chapter 2.

[250] Refer back to section 2.7 of chapter 2.

[251] See section 2.1 of chapter 2.

[252] Refer to section 5.4 of chapter 5 on Locus of Control.

The external Locus of Control, as an important coping strategy used during the diagnostic examinations and treatments[253] in *Toward Authentic Dasein*, gradually changes to an internal Locus of Control in *Mapping Out The Future*. Literature indicates that an external control does not suddenly become an internal control. It is a progressive change from the former to the latter (Connors et al., 1994; Hallis and Slone, 1999). As change occurs, patients assert their internal Locus of Control in some areas. In others, patients continue to depend and rely on medical personnel to make decisions for them[254]. As will be demonstrated, Locus of Control is a dynamic state. Patients oscillate between an internal Locus of Control and an external Locus of Control. However, the internal Locus of Control as it relates to *Mapping Out The Future*, will ultimately prevail. Thus, patients' *Mapping Out The Future* is enabled.

In the first counter-movement against an external Locus of Control, patients attempt to find an area of control for themselves. It is a small but significant victory.

> S6: "I was able to change it (the pain) most of the time with breathing."
>
> S4: "I decided to follow a medically supervised training programme to increase my stamina. It is very good."

Gradually, patients increase their assertion of wishes when they feel strongly about an issue. One such area relates to the continuation or discontinuation of adjuvant therapies such as chemotherapy or radiotherapy. In particular chemotherapy is experienced as highly stressful, because the side-effects, e.g., nausea and fatigue, impact patients' well-being considerably. Therefore, some patients decide to discontinue chemotherapy or radiotherapy, when it becomes too difficult for them to bear.

> S5: "I will continue as long as I can bear it well. Otherwise I will simply stop!"
>
> S3: "I have refused the last chemotherapy now!" (. . .) "Now it is over. The chemotherapy won't be continued. I am very relieved."

---

[253] Compare to section 3.2 in chapter 3, section 5.4 of chapter 5, and Meerwein (1998: 106ff).
[254] Also confer with section 3.2 in chapter 3.

Decisions about discontinuation of adjuvant therapies such as chemotherapy are not taken lightly. Patients are well aware of the potential dangers of discontinuation. However, assertion of their own decision influences well-being positively. They feel relieved to have decided against the treatment. It helps them to conserve their energy and well-being that are important resources in illness management. As a result, they are better able to return to everyday life and to consider their future. Nevertheless, bad experiences during treatments are not forgotten. Fear and Anxiety remain at the back of their minds[255]. Remembered negative experiences regarding anti-cancer treatments are an important matter. In oncology, close monitoring of anti-cancer treatments and the investigation of treatment effects aim at reducing detrimental physical effects on the patient (Black and Morrow, 1991; Glaus Hartmann, 1999; Habr-Gama et al., 1998; Margulies et al., 1994; Redmond, 2000; Watson, 1991). Various methods have been suggested to relieve negative memories or to prevent their development (Glaus et al., 1997; Margulies et al., 1994; Meerwein, 1998: 63ff). Psychological well-being is impacted negatively by chemotherapy, radiotherapy and surgical treatments. Therefore fatigue, bodily changes due to treatments and other issues are subject to research and constant development (Glaus, 1993; Glaus et al., 1997; Glaus et al., 2002; Glaus and Senn, 2001; Margulies et al., 1994; Ream and Richardson, 1999; Redmond, 2000)[256]. The impact of bad memories takes up the importance of the Existential Temporality[257]. Through it, an individual is enabled to consider her life and herself as if outside herself. Aloofness supported by Temporality offers a wider angle and necessary distance to analyse a person's life. Past events, actual situations and the future are drawn into perspective. An actual situation can be assessed and evaluated in consideration of the past, as well as the future. Hence, past and present form a basis for *Mapping Out The Future*.

---

[255] Consult sections 5.1 and 5.4 of chapter 5.

[256] Also refer to section 3.4 of chapter 3.

[257] See section 2.6 of chapter 2.

At different stages in the disease process, other areas emerge for patients to assert their internal Locus of Control. Before the diagnosis of colorectal cancer is disclosed, patients try to retain an internal Locus of Control by attempting to treat the illness symptoms themselves.

> S3: "I had been constipated. At the doctor's - I usually don't go to see the doctor - I said: I will cure myself of these haemorrhoids. Already then the doctor had wanted to send me to the hospital. But I didn't want to go!"

As time progresses, support from healthcare agencies such as community care are no longer necessary on a daily basis. The newfound courage to assert themselves leads to decisions about further examinations in the disease process.

> S1: "The Spitex[258] still comes by. - They came every day to change the dressing. Now they only come every other day. - I asked him (the doctor) if they have to come every day. I'd rather they wouldn't (come on daily basis). - He answered: fine, fine, without question."
>
> S1: "I had been to see the doctor at the hospital. When I had asked how it was, he shrugged his shoulders and answered that he didn't know. He offered to do another colonoscopy which I declined."

A vital area in which the patients exercise a regaining of an internal Locus of Control is in the amount and kind of information imparted to families and friends[259]. Patients decide for themselves with whom they will discuss cancer and in what form.

> S6: "I don't want to discuss this with my daughters and my husband now. I will not."
>
> S6: "It doesn't bother me at all to talk about my illness. It isn't a secret. If I want to trust somebody, I can do so."

In some cases, patients are offered psycho-oncological or psychological support. According to Meerwein (1998: 126ff) psychological support is helpful in enhancing the openness of the relationship between patients and the medical care team[260]. However, patients in this study do not accept these offers.

> S5: "He said that I could go to a psychiatrist here and they would look after me. - I said that I don't need a psychiatrist." (. . .) "Up to now, I have always made my own decisions concerning my life!"

---

[258] „Spitex" corresponds to the English 'community nurse'

[259] Also consult sections 3.5 and 3.6 in chapter 3, as well as section 6.2 in this chapter.

[260] Refer to sections 3.3 and 3.4 of chapter 3.

> S6: "I didn't tell anybody else apart from the family! It isn't anybody else's concern. I don't convey my fears outwardly, even to a psychiatrist."

Rather than talking with psychologists or psycho-oncologists, patients relish opportunities to talk with other patients in similar circumstances or with friends and other acquaintances.

> S3: "Patients talk with each other. - You can talk about it (the cancer) and then it goes away. You are very happy about each day you feel better."
>
> S6: "I highly value the help of neighbours who drive me to the hospital. Also, I told my friends from the tennis club about my problem and they encouraged me to play tennis again as soon as possible. They won't mind the colostomy."

Patients' willingness to cultivate discussions about the disease with people other than their families corresponds to the important place of social support as it has been represented in the literature (Bui et al., 1992; Faller, 1998; Leppin and Schwarzer, 1997; Northouse et al., 2000; Schröder, 1997)[261]. There is evidence that a high level of social support impacts coping process and decisions favourably. However, further exploration in this area is necessary (Leppin and Schwarzer, 1997)[262].

As a result of the disease, patients submit to uncomfortable and hurtful examinations (Faller, 1998: 77ff). In the process, they develop negative feelings that motivate them to regain an internal Locus of Control. Difficult situations that involve healthcare professionals' interventions are also motivating factors in fostering the development of an internal Locus of Control. Experiencing negative attitudes from some doctors and nurses towards patients, or being confronted with doctors that patients think are not good clinicians; foster the regaining of an internal Locus of Control.

> S1: "He (the doctor) doesn't have to send me there again. Never." (. . .) "I won't have another colonoscopy."
>
> S1 (smiling): "But I did tell him directly: You won't touch me again."

Regaining an internal Locus of Control is an important step towards returning to everyday life. In changing from an external Locus of Control to an internal Locus of

---

[261] Consult section 3.4 of chapter 3.

[262] Also see Appendix G.

Control, patients make use of their Understanding and Temporality[263]. Their actual situation is assessed and evaluated in the light of their past and present experiences, as well as their ideas and visions for the future at this point. Due to changes in the actual situation, future outlook on life is subjected to critical evaluation, and adaptations may be implemented. Patients are thus enabled to conceptualise new possibilities tailored to the new situation in which they find themselves. Therefore, patients' experiences reveal the interconnectedness of the Existentials Understanding and Temporality[264].

Increasing awareness of the Self is at the heart of an authentic Dasein when patients move toward an internal Locus of Control. As time passes, patients' conceptualisations of the present are modified, as are their future possibilities. Thus, they are able to *Map Out* their *Future* once again.

An important step toward regaining an internal Locus of Control is learning to care for the ileostomy or colostomy[265]. Initial confrontation with an ileostomy or colostomy is difficult to absorb. At first, feelings of repugnance, Fear and Anxiety are paramount. Learning to care for the ileostomy or colostomy signifies a personal triumph for the patients.

> S3 (proudly): "I am no longer afraid of the ileostomy." (. . .) "I have learned to handle it!"

Overcoming the repugnance and negative feelings about the ileostomy or colostomy becomes an accomplishment, a goal. It is a source of pride when achieved. Statements by healthcare professionals confirming the patients' new-found abilities are motivating.

> S2: "I can care for the ileostomy very well now. The stoma-nurse said that I do it very well."
>
> S4: "As I am managing the colostomy so well, the stoma-nurse has asked me, if I would give advice to other colostomy patients. I will do this gladly."

---

[263] Compare to sections 2.2 and 2.6 in chapter 2.

[264] Further reading in King (2001: 29ff) and Luckner (1997: 125ff).

[265] See section 3.4 in chapter 3.

Patients work hard to cope with negative experiences and hurtful examinations. Having achieved the goal of managing the ileostomy or colostomy by themselves provides patients with more freedom. They are confident in their achievement.

Regaining an internal Locus of Control influences patients' attitudes about themselves. A basically positive attitude supports coping with Uncertainty. In addition, patients believe in being respectful towards themselves and their bodies.

> S6: "I do believe that if one is sufficiently loving to oneself, one takes action then."
>
> S7: "Now I am really looking forward. - With will you can reach something; you can reach a lot."

Good screening results also support regaining an internal Locus of Control. They become a source of happiness, relief, and motivation. Returning to everyday life becomes possible and the future can be re-conceptualised.

> S6: "I was very relieved. - I was almost floating on air, I was so happy."

Regaining an internal Locus of Control means making plans that often promote healthy living. Other patients note that their problem solving process has changed. They are less inclined to become over-excited about minor issues than they were before. The diagnosis of colorectal cancer becomes an incentive to change for the better. It becomes a motivation for patients to change their outlook on life in general[266].

> S7: "I have stopped smoking after the diagnosis." (. . .) "The diagnosis offers a reason to somehow start a new life. I want to be more careful in future and look better after myself." (. . .) "Since the diagnosis I live life more consciously. Things that have upset me before are less important now. I have changed."

Struggling to gain an internal Locus of Control takes up the notion of authentic Dasein that is primarily concerned with its own and unique potentialities. However, authentic Dasein never lasts long. It is easily sabotaged as Dasein chooses Inauthenticity over Authenticity in everyday life[267]. The movement of abandoning Authentic-

---

[266] Compare to section 3.4 in chapter 3.
[267] Refer to section 2.5 in chapter 2.

ity and returning to Inauthenticity is termed being 'Thrown back' (Heidegger, 1998: 13/13E). As inauthentic Dasein there are no differences to other Dasein. Within the They, all Dasein are submerged. Individuality is not fostered. However, Levelling-down of the They (Heidegger, 1998: 9/9E) is the basis of distinction that authentic Dasein needs as an incentive. Therefore, Authenticity is only possible through Inauthenticity[268]. The interrelatedness of Inauthenticity and Authenticity may account for the reconfiguration of patients' Locus of Control. It is also apparent that change, which provokes inauthentic Dasein to choose Authenticity or causes authentic Dasein to be Thrown back into Inauthenticity impacts Dasein's Understanding. The actual situation in the present undergoes change, thereby provoking a critical evaluation of future plans. Individual Understanding is modified, resulting in new projections of possibilities and a reconfiguration of the future. Patients' coping processes correspond to the interrelatedness of Inauthenticity and Authenticity, involving their Understanding. Thus, their *Mapping Out* a new *Future* is enabled.

6.4. Mapping Out The Future - Summary

A diagnosis of colorectal cancer disrupts patients' lives. Examinations and treatments lead at first to a loss of their internal Locus of Control. Patients experience a change from an internal Locus of Control to an external Locus of Control as a coping mechanism in *Toward Authentic Dasein*. Finding a way back to their independence means asserting themselves and re-establishing an internal Locus of Control in *Mapping Out The Future*. The sub-category *Mapping Out The Future* represents a move back to patients' everyday routine and finding a way to manage their situation meaningfully. Everyday life and familiar routine are not easily embraced. In case of

---

[268] Further reading in Mulhall (1996: 69ff).

a stoma, such as an ileostomy or colostomy, return to everydayness is not straightforward. Patients have to adjust to the new body image and learn new skills. Managing a stoma becomes a victory and is an important step toward regaining an internal Locus of Control.

Returning to everyday life is once more possible. Taking up the routine tasks of life becomes a way of regaining control over one's life, as opposed to the disease being in control. It becomes possible to allocate the cancer to a specific place in life[269].

Various coping strategies are developed to regain an internal Locus of Control so as not to become too weighed down with problems. These strategies promote motivation. Family and healthcare professionals play a pivotal role in patients' regaining an internal Locus of Control[270].

Having been diagnosed with cancer has a profound impact on patients' lives. They change their outlook; modify their Understanding of life and their attitudes and beliefs. Heidegger (1993a: 143ff; 1996: 182ff) called this the process of projecting one's future Understanding. The Heideggerian notion of Understanding actually means *Mapping Out The Future.*

---

[269] Refer to sections 3.5 and 3.6 of chapter 3.

[270] Compare to sections 3.5 and 3.6 of chapter 3.

"Indeed in the back of my mind it is always there. I can't put it away completely. Yes, it is there. The feeling that now you are one of those." (S6)

7. The Omnipresence of Cancer

In this chapter *The Omnipresence of Cancer* is explicated (see figure 8.1). It represents the answer to the main research question "What is the Da-sein of Colorectal Cancer?", as well as the secondary questions, which were: "What does it mean to receive a diagnosis of colorectal cancer and its prognosis?" and "Does this meaning change over time and if so, how?"[271]. *The Omnipresence of Cancer* constitutes the essence[272] of the study *The Da-sein of Colorectal Cancer*[273]. As an essential structure, *The Omnipresence of Cancer* represents a theory, which is comprised of two sub-categories, namely, *Toward Authentic Dasein*[274] and *Mapping Out The Future*[275]. These two sub-categories relate to a number of Existentials[276] that are associated with Heidegger's writings in *Being and Time* (1993a; 1996) and are relevant to the findings in this research project. Subsequently, this chapter associates the theory of *The Omnipresence of Cancer* with Heidegger's Ontology of Dasein (1993a; 1996) and relevant literature as presented in the literature review[277].

The main feature of *The Omnipresence of Cancer* is the importance of the disease, i.e., colorectal cancer, and subsequent illness experienced by an individual. Heidegger's Ontology of Dasein (1993a; 1996) offers a description of an individual's existence in the world and everyday life. For human existence the Existentials State-of-mind and Understanding[278] are key to experiencing life and finding meaning in life. Analysis of the data collected in this study highlights that the Existentials Being-in-the-world, State-of-mind, Understanding, Being-with including Solicitude

---

[271] Refer to section 1.2 of the introductory chapter.
[272] See pages 14ff containing the essential structure represented in a story.
[273] Due to the interrelatedness of *The Da-sein of Colorectal Cancer* and *The Omnipresence of Cancer* similarities are unavoidable.
[274] See chapter 5.
[275] Consult chapter 6.
[276] For further reading see chapter 2 on Heidegger's Ontology of Dasein.
[277] Also see chapter 3.
[278] Consult sections 2.2 and 2.3 in chapter 2.

and the They, the two modes of Being that are Authenticity and Inauthenticity[279], all play their part of Dasein's *Omnipresence of Cancer*. In addition, *The Omnipresence of Cancer* draws on the embracing Existentials of Care and Temporality[280], as well as Being-towards-death and death[281], which limit human existence. *The Omnipresence of Cancer* has implications for nursing practice. In the concluding chapter of this thesis implications and recommendations for nursing practice, education and areas for more in-depth research will be addressed.

7.1. Toward Authentic Dasein

The sub-category, *Toward Authentic Dasein,* refers to feelings and reactions that people experience when they are confronted with a diagnosis of colorectal cancer. *Toward Authentic Dasein* encompasses three constructs that are Uncertainty, Transitoriness and Locus of Control[282]. Underpinning the sub-category, *Toward Authentic Dasein,* is Fear ["Furcht"] as a mode of State-of-mind and Anxiety ["Angst"] that is basic State-of-mind (Heidegger, 1993a: 140ff; 1993a: 184ff; 1996: 179ff; 1996: 228ff)[283]. As was demonstrated, Fear and Anxiety are predominant at the beginning of the illness, but they may diminish over time. However, the disease remains present in people's minds, even when it is allocated a place in the back of their minds. Although Fear and Anxiety are predominant, the experiences of a person who is diagnosed with cancer can be better explained by further drawing on Heidegger's Ontology of Dasein (1993a; 1996)[284]. In the subsequent paragraphs, the ontic-

---

[279] See chapter 2 for more details.
[280] Consult section 2.6 in chapter 2.
[281] Compare to section 2.7 of chapter 2.
[282] Refer to sections 5.1, 5.3 and 5.4 of chapter 5.
[283] More details in section 5.1 of chapter 5.
[284] Confer to chapter 5.

empirical nature of *The Omnipresence of Cancer* will be illuminated by juxtaposing Heidegger's Ontology of Dasein (1993a; 1996) to relevant literature.

The construct Uncertainty can be linked to Heideggerian Fear and Anxiety (1993a: 140ff; 1993a: 184ff; 1996: 179ff; 1996: 228ff). In relation to Transitoriness Heidegger's embracing Existentials of Care and Temporality (1993a: 191; 1993a: 231; 1996: 235; 1996: 274), as well as his perspective on Being-towards-death and death (1993a: 258ff; 1993a: 329; 1996: 302; 1996: 377) are of importance[285]. Locus of Control corresponds to the influence of the Existential the They on a person's perspectives and attitudes[286].

7.1.1. Uncertainty

In the construct Uncertainty a person's feelings and reactions as they arise with the first symptoms of the illness are comprised. Other sources of Uncertainty appear in the course of the illness, such as confrontation with the diagnosis of colorectal cancer, treatments and screenings. At first, people do not understand what is going on and what is wrong. Their everyday knowledge about bodily changes is insufficient and satisfactory answers about the changes occurring in their bodies are not readily available. The importance of bodily changes is not immediately recognisable as Uncertainty manifests itself and moves to the forefront of their minds. Only persistence in the symptoms and feelings of being unwell will lead a person to consult a physician. Subsequent examinations intensify Uncertainty, which then becomes a source for Fear and Anxiety[287].

The individual primarily experiences Uncertainty as the reason for feeling unwell and the symptoms manifesting themselves cannot be clearly identified at this point. Thorough examinations, however, are confirmation for a person's hunches about the

---

[285] See section 5.1 of chapter 5, as well as sections 2.6 and 2.7 of chapter 2.

[286] Consult section 5.4 of chapter 5, and section 2.4 of chapter 2.

[287] Consult section 5.1 of chapter 5 for more details.

gravity of the illness. In this instance, Uncertainty relates to Heideggerian Fear (1993a: 142; 1996: 182). Any entity within the world - be it present-at-hand, ready-to-hand or another Dasein - may become a source for Dasein's Fear. Feeling unwell together with the illness' symptoms can thus be seen as entities present-at-hand existing within the world. They manifest themselves to the person concerned in the manner of approaching suddenly. The development of the disease expressed by the symptoms has gone unnoticed. It is, therefore, regarded as a threat[288]. The disease is perceived as something dreadful.

> ". . . where that which threatens is laden with dread, and is at the same time encountered with the suddenness of the alarming." (Heidegger, 1993a: 142; 1996: 182).

Whatever a person fears is a threat, and the closer it approaches, the more Fear intensifies. Depending on the speed of the approach, Fear turns into Alarm and as a third and ultimate state into Terror (Heidegger, 1993a: 140-142; 1996: 179-182). The entity that is feared becomes a burden. It fosters Dread in the individual. How and when the threat approaches is uncertain and as such is outside people's control. Uncertainty is reinforced. These characteristics correspond to Heideggerian Fear and its essential properties (Heidegger, 1993a: 142; 1996: 182).

With the disclosure of the diagnosis of colorectal cancer, Uncertainty in relation to the cause of the bodily changes abates. However, receiving a diagnosis of colorectal cancer signifies a life-threat. The individual's Fear and Anxiety intensify, challenging her views and beliefs about life and future. Everyday routine is disrupted, thus becoming a new source of Uncertainty.

When individuals experience Fear, they become confused and lose all sense of direction (Heidegger, 1993a: 141; 1996: 181). People lose a sense of being themselves. They are no longer able to relate to the world around them as they loose

---

[288] Refer to sections 5.2, 5.3 and 5.4 of chapter 5.

their grounding. Fear becomes pervasive and all prevailing[289]. Any other issues, wishes or thoughts are pushed aside and are no longer important. Fear becomes all determining as long as the entity provoking it is approaching and influencing the individual.

With the disclosure of the diagnosis of colorectal cancer, Fear turns into a more general fear of life. Cancer is considered a life-threat (Bain et al., 2002; Reinacher-Schick and Schmiegel, 2002; Semmens et al., 2000). An individual's life plans have to be put on hold. Through the diagnosis of cancer, a person experiences an abrupt end to life as it is known. At this instance, individual experience relates to Heideggerian Anxiety (1993a: 184ff; 1996: 228ff). As opposed to Fear, the source for Anxiety in Dasein is "Being-in-the-world as such" (Heidegger, 1993a: 186; 1996: 230). Anxiety is therefore fear for life. Thus, it is more profound and upsetting than Fear. In addition, Anxiety is provoked by less concrete issues than Fear. Thus, Anxiety is more difficult to deal with than Fear. Anxiety is at the same time fear of life and fear of death. It is an expression of existential doubt (Heidegger, 1993a: 190; 1996: 234)[290]. As Anxiety can provoke a profound upheaval, the person is brought before her Self. Thereby the individual's possibility to move *Toward Authentic Dasein* is revealed. Nevertheless, Fear does not exist without Anxiety according to Heidegger (1993a: 185; 1996: 230). Receiving a diagnosis of colorectal cancer illustrates the alternating interrelationship of Fear and Anxiety.

Succeeding the confrontation of a diagnosis of colorectal cancer, an individual has to submit to various treatments that include surgical removal of the malignant growth. Consenting to treatment is one thing, but experiencing it is another. In relation to surgical intervention strong feelings of pain or suffering are described[291].

---

[289] Compare to sections 5.2 and 5.3 of results and discussion chapter 5.

[290] Also consult Luckner (1997: 80-90).

[291] Consult section 5.2 of chapter 5.

Fear and Anxiety prevail when benefit of treatments is uncertain. At this time there is no guarantee that treatments will reinstate an individual to perfect health[292].

During the treatment period, Uncertainty is less evident[293]. Completion of treatments is assumed to bring some relief. However, treatments are followed by screenings and these may have an even greater impact on a person's sense of well-being[294]. Patients are asked to follow a strict screening schedule to monitor the body and the effects cancer has had or is having, if uncontrolled. In general, the first screening takes place three months after conclusion of treatments, increasing to six and twelve months intervals. Screenings occur for five years. It is not until the deadline of the fifth year, with no further indication of relapse, that a person is considered cured. However, there is no unanimous, international agreement about follow-ups (Senn, 1997a; Weiss and Johnson, 1999). Nevertheless, screenings become a major source of Uncertainty. With each screening feelings of Fear, in the form of Dread, and Anxiety occur[295]. What is ordinarily termed feeling, such as Fear, is a mood and is expressed correspondingly by the person. Moods, however, are the ontic expressions of Dasein's State-of-mind (Heidegger, 1993a: 134ff; 1996: 172ff). Through State-of-mind, the importance of moods and their impact on human perceptions and experiences is illustrated. By linking the ontic experiences of the patients in this study to Heidegger's Existential State-of-mind (1993a: 134ff; 1996: 172ff), further insight into the pivotal role of Uncertainty and its impact on human beings diagnosed with colorectal cancer was gained. Through the importance of State-of-mind and its ontic expression moods, Uncertainty is instrumental for the cancer to become Omnipresent.

---

[292] Refer to section 5.2 of chapter 5.
[293] Corresponding findings can be found in sections 5.2 and 5.4 of chapter 5.
[294] Consult sections 5.2, 5.3 and 5.4 in chapter 5 for substantiation.
[295] See also sections 5.2 and 5.4 in chapter 5.

Cancer is one of the most frightening diseases that may befall a human being. It causes an abrupt end to any plans a person may have for the future (Glaus et al., 1997; Kübler Ross, 1996; Meerwein and Bräutigam, 1998). Literature describes the reactions people have when confronted with a fatal disease. On receipt of a diagnosis of cancer individuals suffer deep shock (Meerwein, 1998; Senn, 1997b; Senn and Glaus, 1998). In view of potential death, deep and abiding fears and anxieties have been identified as being significantly stronger in cancer patients (Käppeli, 1998: 74). An individual may even develop a psychological disorder leading to depression (Faller, 1998: 20ff; Meerwein and Stiefel, 1997: 266ff; Redmond, 2000: 70). The shock of being told about a diagnosis of cancer has been widely discussed in medical literature[296]. Several suggestions have been made about how to improve 'breaking bad news' or soften the blow (Buckman, 1989; Burton, 1991; Glaus et al., 1997; Meerwein and Bräutigam, 1998; Sahay et al., 2000; Schwarz, 1985). However, in the end, individuals receiving the news have to deal with the knowledge themselves. They must understand that a diagnosis of cancer means a threat to life and a disruption to everyday life. Research indicates that coping strategies influence illness treatment and outcome significantly. Patients monitoring their health status closely have a more positive outcome, particularly when they receive adequate information tailored to their needs (Grahn, 1993; Grahn and Johnson, 1990; Miller, 1995; Nettleton and Gustafsson, 2002; Nordin and Glimelius, 1997; Stiggelbout et al., 1997).

Receiving a diagnosis of colorectal cancer incites a person to question the origins of her illness. Where did it come from? Why me? Patients diagnosed with cancer or other life-threatening diseases are extremely interested in its causes and connections. They are eager to find an explanation to the question of why they have the disease (Filipp and Aymanns, 1997; Schröder, 1997; Faller, 1998)[297]. Attempting to identify a reason for having cancer or another fatal disease is a way to relieve Un-

---

[296] See sections 3.3 and 3.4 of chapter 3.

[297] Compare to sections 3.2, 3.5 and 3.6 of the literature review. For substantiation refer to section 6.1 of the results and discussion chapter 6.

certainty, as well as an important resource and first step in the individual's coping process (Filipp and Aymanns, 1997). As soon as feelings of Fear have abated, people must ground and re-orientate themselves again[298] to counter-act the loss of grounding and to relate again to the world. Maintaining one's self-esteem and a positive attitude towards oneself when searching for an explanation, however, is more difficult if a concrete reason for the disease can be found, such as having developed a bronchial carcinoma because of smoking (Faller, 1998). Searching for a reason for having a fatal disease such as cancer is attributed to the second phase of 'anger and rage' by Kübler-Ross (1996)[299]. Identification of the stages of an individual's coping process and attributing it to one or other phase in a model like Kübler-Ross' (1996) may be helpful in understanding Fear and Anxiety experienced by individuals themselves and also to doctors and nurses involved in their care[300]. However, attributing patients' reactions to one or other phase in a model presents difficulties, because clear definitions for each phase are not provided (Schwarz and Hornburg, 1994; Schröder, 1997).

Foucault (1968: 31ff) discussed illness in-depth. Psychological disturbances were of particular interest to the philosopher (1968: 31ff)[301]. Illness was recognised as having two opposite sides: a detrimental and a restoring side. Both sides alternate, but may also complement each other (Foucault, 1968: 32). Human life is impacted considerably by illness. Change may occur that can either be beneficial or hindering (Foucault, 1968: 32ff). Illness is closely interrelated with an individual's life and history. Fear is a key element in causing illness (Foucault, 1968: 71). To deal with illness satisfactorily, it is necessary to comprehend fear and what its cause might be. In the attempt of understanding fear in relation to illness, Foucault (1968: 74) stated that a sick person has a totally individual perception of illness. Any other

---

[298] Also see Gelven (1989: 85-86) and Mulhall (1996: 77-79).

[299] See section 3.5 in chapter 3.

[300] Compare to sections 3.5 and 3.6 of the literature review. Also consult section 5.2 of chapter 5.

[301] See section 3.1 of the literature review. Also consult Helferich (2000: 429-432), and Kunzmann et al. (2001: 239).

individual, for example a healthcare professional, will never share exactly the same perception. There will always be a difference (Foucault, 1968: 74). Recognition of the differing perspectives of the afflicted and healthy people towards illness improves the management of the disease process (Foucault, 1968: 75)[302].

7.1.2. Transitoriness

Equally important in *Toward Authentic Dasein*, is the construct Transitoriness. It encompasses an individual's perspective on the fatality of the disease and confrontation with death. Recognition of the severity of the disease provokes the afflicted into thinking about death and their impending demise. As soon as people are told of their diagnosis of colorectal cancer, the thought of death pushes itself to the forefront of their minds. The fact of death is no longer a remote possibility; it becomes a very real option[303]. With the diagnosis of colorectal cancer, thinking about death cannot be avoided (Faller, 1998; Markowitz et al., 2002; Saddler and Ellis, 1999; Semmens et al., 2000). Although medical progress has developed curative treatments for some forms of cancer, society maintains the belief that cancer is fatal in all cases (Faller, 1998; Senn and Glaus, 1998). Therefore, a diagnosis of cancer substantiates Fear and Anxiety. Perspectives on the individual's existence and future are challenged. Thoughts of impending death add to Uncertainty already experienced.

Confronting the finitude of human existence, i.e., the possibility of death is very difficult. Although people know that there will be an end to life at some point, the knowledge is not present in each moment. However, once diagnosed with cancer brings the thought of death to the fore. It cannot be avoided[304] (Faller, 1998; Meer-

---

[302] Confer to section 3.2 chapter 3.
[303] See section 5.3 of chapter 5.
[304] Compare with section 5.3 of chapter 5.

wein and Stiefel, 1997; Redmond, 2000). Thoughts about the fact of death in human existence and consideration of impending demise are not reserved for just the beginning of the illness. The appearance of the first symptoms of the disease generally provokes Uncertainty as the significance of the symptoms is difficult to interpret. However, being told about having colorectal cancer means confirmation of a fatal disease. From then on, the fact of death in human existence can no longer be denied. Patients are confronted with their mortality. Colorectal cancer, therefore, becomes not only a life threat, but an enemy of human existence. Thoughts of death and consideration of the finitude of human existence accompany the individual from the confirmation of the diagnosis of colorectal cancer onward. They remain present even after the conclusion of the treatments. Due to confrontation with the finitude of one's existence, individuals see themselves as belonging to a segregated group of people who have cancer. They now are "Einer von denen" - "one of those". A diagnosis of colorectal cancer is a stigma that cannot be removed[305]. Neither the conclusion of treatments, nor positive screening reports that confirm restoration to health remove the stigma. The feeling of being stigmatised and belonging to this segregated group persists (Faller, 1998; Flanagan and Holmes, 2000; Schulte, 2002; Senn, 1997b: 250; Senn and Glaus, 1998).

Only time blunts initial feelings of Fear and Anxiety provoked by being told about having colorectal cancer. Time offers local and temporal distance to the transitory nature of human existence[306]. A tight regime of treatments supports individuals in distancing themselves from a confrontation with death. However, Fear and Anxiety provoked by the finitude of human existence remain at the back of an individual's mind. Literature indicates that thoughts about death can be pushed away, particularly during treatments[307] (Bürgin and Di Gallo, 1998; Kübler-Ross, 1996; Meerwein

---

[305] Compare to section 3.4 of chapter 3.

[306] Consult section 2.6 in chapter 2.

[307] Also see section 3.5 in chapter 3.

and Stiefel, 1997), but can never be totally forgotten[308]. The longer a person survives whilst undergoing treatments, the more hopeful she grows. Uncertainty persists, but thoughts about impending death retreat to the back of her mind. Fear and Anxiety are held at bay or abate[309].

In Heidegger's Ontology of Dasein (1993a; 1996) Being-towards-death and death also play important roles. As cancer is a life-threat, the individual is confronted with her mortality. Thus, the person is brought before her Self. The confrontation with one's own death reveals Dasein's possibility for Authenticity. It is now possible for the individual to glimpse her authentic Dasein. There is a choice revealed to the person, either to move *Toward Authentic Dasein* or to remain in Inauthenticity. In consideration of this choice, the individual takes into account her past and the present, as well as future ideas and plans. Thereby, the embracing Existentials Care and Temporality are introduced[310]. However, the two modes of Being - Authenticity and Inauthenticity[311] - play pivotal roles in an individual's confrontation with her Transitoriness as an expression of *Toward Authentic Dasein.*

In Heidegger's Ontology of Dasein (1993a; 1996), terms such as 'fatal disease' or 'diagnosis' are not explained, because the ontic-empirical level of experience is not of relevance in his description of Dasein. The passages below introduce Existentials of Heidegger's Ontology of Dasein (1993a; 1996) that are of importance.

> "In so far as running ahead to this past maintains the past in its specific 'how', the 'how' of Dasein itself becomes visible. Running ahead to the past is Dasein's running up against its most extreme possibility; and in so far as this 'running up against' is serious, Dasein in this running is thrown back upon itself as still Dasein." (Heidegger, 1998: 12/12E-13/13E).

To understand this text, the following passages are vitally important.

> "Dasein has in itself the possibility of meeting with its death as the most extreme possibility of itself." (Heidegger, 1998: 11/11E).

And:

---

[308] Substantiation is found in chapter 5, section 5.3 and 5.5.

[309] See section 5.3 of chapter 5.

[310] For more information see chapter 2, as well as Dreyfus (1995)

[311] See section 2.5 of chapter 2.

> "The Being of possibility here always is the possibility in such a way that this possibility knows of death, for the most part in the sense that 'I already know, but am not thinking about it'. For the most part I know of death in the manner of a knowing that shrinks back." (Heidegger, 1998: 12/12E).

The awareness of people having a limited time-span at their disposal is reflected in the essential mode of Care, which is Being-towards-death. Death is considered to be the unique, ultimate and last possibility of human existence. It is the end. After death, nothing seems to follow. Dasein is no longer and, therefore, it is no longer of the basic condition of Being-in-the-world (Heidegger, 1993a: 238; 1996: 281-282)[312]. Death is the end of an individual. It cannot be avoided. However, a healthy person has little reason to think about it intensively or to fear its immediate approach. Nevertheless, every person will die at some point. When, where or how is not known. Facing death may happen, because there is a reason to do so. It is up to individuals themselves whether they allow themselves to be confronted with the transitory nature of their existence and their demise. Being told about having colorectal cancer may be a reason for individuals to consider the finitude of human existence and to accept the possibility of impending demise.

Being-towards-death and the fact of death are not invested with any value judgement in Heidegger's Ontology of Dasein (1993a; 1996). However, accepting the thought of the Transitoriness of human existence appears to have advantages. Choosing to consider potential death and therefore the end of human existence makes a difference to the individual reflecting upon it. A person may glimpse her authentic Dasein. It is then possible for the individual to consider her own unique possibilities and to attempt working toward them. Authentic Dasein, however, is not a state which once gained remains for ever. It is a way of Being that is in constant development. The individual freely chooses whether to move *Toward Authentic Dasein* or not. At that, it is possible for the human being to glimpse Authenticity[313].

---

[312] Also consult King (2001: 150ff) and Solomon (1972: 225).

[313] See section 2.5 of chapter 2 and also consult Gelven (1989: 136-155).

In some instances, it is possible for a person to become authentic Dasein temporarily. However, human beings only achieve temporary Authenticity. It is not a stable state, but subject to changes. Eventually, a person returns to or rather is thrown back into everyday life, as Dasein exists primarily inauthentically[314].

In consideration of Heidegger's (1993a; 1996) perspective on Fear and Anxiety, any fatal illness or a severe accident may offer an incentive to consider authentic or inauthentic Dasein. These two modes of Being have to be accepted without value judgement (Gelven, 1989: 53). Authenticity and Inauthenticity are simply ways of Being and are choices for human beings to choose at any time in their lives. Choosing authentic Dasein means focusing on the individuality of human beings and to work toward realisation of their own unique and particular possibilities.

> "In each case Dasein is its possibility, and it 'has' this possibility, but not just as a property [eigenschaftlich], as something present-at-hand would. And because Dasein is in each case essentially its own possibility, it can, in its very Being, 'choose' itself and win itself; it can also lose itself and never win itself; or only 'seem' to do so. But only in so far as it is essentially something which can be authentic - that is, something of its own - can have lost itself and not yet won itself." (Heidegger, 1993a: 42-43; 1996: 68).

Inauthentic Dasein, by contrast, is Dasein existing within the They. It is the Dasein of the everyday. As such it has lost itself within the They. The possibilities for Dasein are those of the They, and therefore they are of an average kind.

> "The Self of everyday Dasein is the they-self, which we distinguish from the authentic Self - that is, from the Self which has been taken hold of in its own way [eigens ergriffenen]. As they-self, the particular Dasein has been dispersed into the 'they', and must first find itself." (Heidegger, 1993a: 129; 1996: 167).

In everyday life, an individual is part of society. As such, she accepts the beliefs, attitudes, goals and aims of society as her own. The individual lives everyday life according to society's norm. Authenticity, on the other hand, means taking hold of Dasein's own self and becoming distinguishable from other Dasein who are part of the They. Individuals choosing Authenticity focus on their own beliefs and attitudes. They are concerned with their own Dasein, goals and aims that may differ from

---

[314] Compare to section 6.1 and 6.3 of chapter 6.

those of society[315]. Thus the individual stands out from society and becomes distinguishable from other people in society.

Throughout life, people are aware of and live towards death. However, the fact of death is only considered when there is an incentive. Any event or matter that provokes deep Fear and Anxiety may constitute a motivation to consider inauthentic and authentic Dasein, Being-towards-death and death. Being told about having a fatal disease constitutes an opportunity for individuals to consider the potentiality of their demise. Consideration of the finitude of human existence offers a person a glimpse of what it may be that impacts her outlook on life. Authenticity, however, is only temporary. Human beings lose it again and fall back into Inauthenticity or a mode in between, which is called "modally undifferentiated" (Heidegger, 1993a: 53; 1996: 78). By introducing Authenticity and Inauthenticity, Heidegger (1993a: 190ff; 1996: 235ff) stressed that existence is vitally important to human beings (Gelven, 1989: 53). Therefore, death is of great importance, because it constitutes the absolute end to life. If life and existence matter, then the potential finitude of existence matters, too.

7.1.3. Locus of Control

Within *Toward Authentic Dasein* the construct Locus of Control is associated with the They and Temporality[316], involving Authenticity and Inauthenticity[317]. The two preceding constructs of Uncertainty and Transitoriness described feelings and reactions that occur when diagnosed with colorectal cancer. Locus of Control involves the effects of the illness on an individual's life and the management of these reactions.

---

[315] For further reading refer to Gelven (1989: 136-155) and King (2001: 145-162).

[316] Refer to sections 2.4 and 2.6 of chapter 2.

[317] Compare to section 2.5 of chapter 2.

Receiving a diagnosis of colorectal cancer provokes Fear and Anxiety, impacting everyday routine and familiar decision making processes. As soon as the person is told she has colorectal cancer, control in decision making moves from the individual diagnosed to healthcare professionals, i.e., physicians in particular[318]. Medical science deems various treatments appropriate and necessary to combat colorectal cancer. Therefore, doctors and nurses suggest a plan of action. Agreement by the afflicted person is strongly suggested; even expected. Information about treatments is provided; but whether the patient concerned has misgivings or not, there is an expectation that she will accept the treatments. Fear and Anxiety provoked by the diagnosis become all consuming. Accepting decisions suggested by others is a relief for many patients in the early stages of the disease process. They willingly hand over control of their lives to healthcare professionals, because they are trusted to make the correct decisions, in order to enhance patient benefit and well-being. Accepting an external Locus of Control becomes a coping strategy for patients. The professional knowledge of doctors and nurses is considered to be sufficient credence for them to take the right decisions on behalf of the patient's well-being and benefit. Despite information provided by healthcare professionals, patients are often at a loss and unable to make relevant decisions after receiving their diagnosis. They feel therefore relieved when decisions are made by doctors and nurses. Relying on the knowledge and benevolence of healthcare professionals is highly important at an early stage in the disease process[319].

Locus of Control has been of interest to psychology and to economy. It has been described as internal or external (Connors et al., 1994; Hallis and Slone, 1999). An internal Locus of Control is preferable to an external Locus of Control. Having an internal Locus of Control means people actively decide about their own life and make their own choices. An individual is in charge of herself and independent. With

---

[318] See section 5.4 of chapter 5.

[319] See sections 3.2, 3.3 and 3.5 of the literature review.

an external Locus of Control, people are reactive. They are dependent on other human beings to make decisions. In a state of well-being and health, a balance between internal and external Locus of Control is desirable. The individual therefore oscillates between the two loci of control according to the demands of the situation (Connors et al., 1994).

There has been an effort to investigate the functioning and effects of Locus of Control in relation to a diagnosis of cancer. Conclusive evidence that Locus of Control is indeed an important aspect in individuals' preventive care, coping strategies or in illness management has not yet been provided. Findings and conclusions remain inconsistent (Filipp, 1990; Filipp and Aymanns, 1997; Hornung, 1984; 1986). As there is conflicting and tenuous evidence, Locus of Control in relation to illness prevention and management has not been investigated further (Klauer and Filipp, 1997).

Initially, patients diagnosed with colorectal cancer consent to follow the recommendations given by healthcare professionals. Bad experiences with chemotherapy, however, lead to critical examination of the initial acceptance of an external Locus of Control. Along with this, the beneficial effects of anti-cancer treatment are also questioned. There is no guarantee that anti-cancer treatments will prevent a relapse. The uncertain outcome of the treatments against cancer puts the initial willingness to hand over Locus of Control to healthcare professionals under scrutiny[320]. Questioning the beneficence of an external Locus of Control is the first step in regaining an internal Locus of Control. Although Fear and Anxiety are still evident, the impact of the detrimental effects of anti-cancer treatments proves to be stronger. It may lead to discontinuation of the treatments. Critical reconsideration of accepting an external Locus of Control may temporarily change interrelationships. Literature does not describe the relationship between decisions associated with Locus of

---

[320] Consult section 5.4 of chapter 5.

Control related to effects of anti-cancer treatments. In relation to treatments and their effects, the role of doctors and nurses is described as one of professional advice and leadership. Healthcare professionals impart important information to patients so they can exercise informed consent and accept the leadership of the former in the patients' treatment schedules (Dooher and Byrt, 2002; Faller, 1998; Little et al., 1999; Meerwein, 1998; Nettleton and Gustafsson, 2002; Senn, 1997a).

General information about cancer and anti-cancer treatments is readily available in the media. Society has its own perspective on cancer and anti-cancer treatments. Within society each person has her own views and opinions about cancer and anti-cancer treatments, depending on her exposure to the disease[321]. On this basis, individuals form their own opinions and beliefs. Keller and Müller (1994: 271) refer to the difficulties of hear-say and media attention. Information provided by the media is considered to have improved the knowledge base of people. However, television programmes focusing on health problems are subject to various constraints, of which time restraints and tight budgeting have the largest impact. Therefore, knowledge provided by the media is notoriously sketchy and fragmentary. This increases Uncertainty and ignorance. The aim of the media to provide a platform of information about many different aspects of health and illness accessible to all, has to be seriously questioned (Härle, 2001). It is doubtful whether the media can offer sufficient and detailed knowledge about health and illness issues. Information provided by professional organisations, such as the Swiss Cancer League or other self help groups are considered to be more helpful (Burton, 1991; Haller, 1994). The quality of the information offered by media, professional organisations, self help groups and healthcare professionals are important to patients helping them to understand their treatment regime. As it has been demonstrated in *The Da-sein of*

---

[321] Also see section 3.2 of chapter 3.

Colorectal Cancer, the more information and experience patients have about their disease, the more they are interested in regaining an internal Locus of Control[322].

Besides the effects of anti-cancer treatments, additional health problems, such as cholecystolithiasis, scrotal inflammation or flu, may be experienced. These are immediately perceived as complications and are interpreted as a recurrence of the cancer. Ever since receiving the diagnosis of colorectal cancer, thoughts of the cancer are first and foremost in the person's mind. It is a new measure against which anything related to health and illness is evaluated. Fear and Anxiety, sometimes relegated to the back of their mind, are once more all consuming. An internal Locus of Control is gradually regained over the treatment period with the help of information and critical evaluation of the individuals' perception of their health. Only reassurance and verbal expressions of approval by doctors and nurses help to allay Fear and Anxiety provoked by complication. The importance of reassurance and approval by healthcare professionals has been recognised and illustrated by Little et al. (1999). It is very important to cancer patients to be reassured, either verbally or non-verbally, by the medical care team.

Family, friends and acquaintances also assume an important role in illness management. Discussions with family members about initial symptoms help to interpret the meaning of the illness' effect and lead to consultation with healthcare professionals. Patients draw on the opinion and recommendation of family and friends, thereby reflecting an external Locus of Control. Therefore, social support through family and other members of the social network are of high importance to patients confronted with a fatal illness (Bürgin and Di Gallo, 1998; Helman, 1998; Leppin and Schwarzer, 1997; Nettleton and Gustafsson, 2002).

---

[322] See sections 5.4 of chapter 5.

This process reflects Heidegger's Existentials of the They and the They-Self[323]. People exist as part of the They in the everyday world. The They is welcomed as it offers to the individual the avoidance of being responsible. Inauthentic Dasein[324] willingly assumes responsibility as it does not denote one person as such. Individuality is not a primary concern. Views and attitudes of the They offer answers to questions of how. Human beings as part of the They do not have to think about how to react or how to perceive something. It is given as the perspective of the They is accepted totally.

In the experience of having received a diagnosis of colorectal cancer, the change from an internal Locus of Control to an external Locus of Control happens voluntarily as a coping strategy. However, institutional and structural conditions promote and support patients' external Locus of Control[325]. Whatever the reason, as soon as there is an external Locus of Control, it is accepted as given and considered to be helpful. The They, as an Existential, represents Dasein's condition in the everyday world. It is accepted as such and not disputed. Here, the human being loses herself in the They. Individuality is lost. When there is a confrontation with death, and as such the Transitory nature of human existence, individuals may look at it more closely and evaluate the meaning in relation to themselves. Choosing to consider death and the Transitoriness of human existence is a movement *Toward Authentic Dasein*, in which movement is seen between an external and internal Locus of Control. Regaining an internal Locus of Control reflects Heidegger's Authenticity. The focus is on the individual.

---

[323] Refer to section 2.4 of chapter 2 for further information.
[324] Also see section 2.5 of chapter 2 and section 7.1.2 in chapter 7.
[325] Substantiation is provided in section 5.4 of chapter 5.

7.1.4. Summary

Toward Authentic Dasein comprises feelings and reactions when an individual is confronted with a diagnosis of colorectal cancer. Already with the first symptoms of the illness, individuals experience Uncertainty, based on Fear and Anxiety. Too many issues regarding the disease are either unknown or cannot be interpreted correctly. In addition, certainty can only be provided by extensive medical examinations. Colorectal cancer can be described as an entity present-at-hand approaching the individual, thereby generating Fear in the form of Dread (Heidegger, 1993a: 142; 1996: 182) due to Uncertainty. Disclosure of the diagnosis of colorectal cancer offers certainty. However, due to the life-threatening characteristic of the disease, Fear turns into a more general fear of life, thereby turning into Anxiety (Heidegger, 1993a: 184ff; 1996: 228ff). Everydayness as it is known to the individual is disrupted. Outlook on life and future conceptions are challenged. People are confronted with the Transitory nature of their lives that fosters Fear and Anxiety. Taking up everyday life and the comforting oblivion of responsibility as inauthentic Dasein is no longer possible. The individual is brought before herself, i.e., Authenticity beckons. Although authentic Dasein can be associated with an internal Locus of Control, people who are confronted with a diagnosis of colorectal cancer, at first choose an external Locus of Control, thereby confusingly exercising independence. With the course of the illness, the apparent free choice is cemented by institutional and structural conditions. Only thus is it possible for an individual to move from *Toward Authentic Dasein* to *Mapping Out The Future*.

7.2. Mapping Out The Future

The second sub-category, *Mapping Out The Future*, relates to a person's endeavours to return to everyday life and to rebuild some semblance of normality and routine that have been disrupted by the diagnosis and treatments. The primary feature of *Mapping Out The Future* is for the individual to become again able to take up familiar routines and to conceptualise new projects, including plans, wishes and dreams. Underpinning *Mapping Out The Future* are Heidegger's Existentials Understanding and Temporality. They are reflected in the constructs Uncertainty, Transitoriness and Locus of Control. The first construct comprises a person's coping processes to overcome the Uncertainty generated by the disease. Thus, people become more certain; this enables them to return to everydayness. Transitoriness relates to dealing with and learning to live with a diagnosis of cancer. Death is no longer a remote possibility. It has moved to the forefront of the individual's mind. Finally, Locus of Control relates to an individual's strategies to regain an internal Locus of Control that has been given up at the beginning of the disease process. Re-establishing an internal Locus of Control confirms the will to live and to allocate the disease a place in a person's life. Outlook on life has changed, making way for new projects. Regaining certainty and an internal Locus of Control, as well as accepting death as part of human existence, lead to *Mapping Out The Future* based on the changed present.

7.2.1. Uncertainty

After being diagnosed with colorectal cancer, a patient submits to tests and treatments involving close contact with medical institutions and personnel. One of the major sources of Uncertainty, as was discussed in *Toward Authentic Dasein*[326], is the

---

[326] Also consult results and discussion chapter 5.

way information is presented. Information is often vague and sketchy, and widely open to interpretation[327]. Uncertainty arises, because people are unsure how to react to or interpret and evaluate the information according to its importance.

How information flows and how patients are informed in healthcare settings has been debated widely and over decades in the literature (Brewin, 1977; Buckman, 1984; 1989; Burton, 1991; Sahay et al., 2000)[328]. Various suggestions to address the needs of individuals diagnosed with cancer have been published. Doctors and nurses need to examine critically the content of any information, and select an appropriate environment and time to impart it. Many difficult situations may thus be avoided (Burton, 1991; Senn, 1997b: 258ff; Sahay et al., 2000).

Human communication is an important issue in Heidegger's Ontology of Dasein (1993a; 1996). An individual shares the world with other people[329]. She is concerned about herself, as well as other human beings. Expressing concern and interest in other people happens when Speaking with one another[330].

> "Being with one another in the world, having this world as being with one another, has a distinctive ontological determination. The fundamental way of the Dasein of world, namely, having world there with one another, is speaking. Fully considered, speaking is: oneself speaking out in speaking with another about something. It is predominantly in speaking that man's being-in-the-world takes place. This was already known to Aristotle. In the manner in which Dasein in its world speaks about its way of dealing with its world, a self-interpretation of Dasein is also given. It states how Dasein specifically understands itself, what it takes itself to be. In speaking with one another, in what one thus spreads around in speaking, there lies the specific self-interpretation of the present, which maintains itself in this dialogue." (Heidegger, 1998: 8/8E).

In Speaking, the individual has the possibility of revealing herself to other people. Speaking is necessary for an individual to take note of the present, to be able to evaluate and understand it. Therefore how, when and where information is im-

---

[327] See section 3.3 of chapter 3.
[328] Refer to section 3.4 of chapter 3.
[329] Confer to section 2.4 of chapter 2.
[330] Refer back to section 6.1 and 6.2 of chapter 6.

parted has an ontological basis in the importance of Speaking[331]. The amount and quality of the information available to human beings directly impact their Self-understanding and thus their Being-in-the-world.

The medical care team assumes an important role in the experience of having received a diagnosis of colorectal cancer. Uncertainty is closely linked to meeting and Being-with doctors and nurses. Doctors and nurses are sources of knowledge and information. They are key as primary contacts for patients within the medical institution. Therefore, healthcare professionals may assume advocacy roles on behalf of the patient towards family and friends, as well as other medical personnel (Bartter, 2001; Cox and Reyes-Hughes, 2001; Glaus and Meier, 1997: 219; Tschudin, 1990; 161). In addition, human beings who experience the impact of a cancer diagnosis on their lives are eager to discuss in-depth their future and the effects of the illness. However, medical personnel work under many constraints, one of these being severe time limitations. In this situation they are not always able to engage in prolonged discussions[332]. Lack of information therefore becomes noticeable and Uncertainty is increased.

> "As this being-in-the-world, Dasein is, together with this, being-with-one-another, being with Others: having the same world there with Others, encountering one another, being with one another in the manner of being-for-one-another. Yet this Dasein is simultaneously being present at hand for Others, namely, just as a stone is there which neither has nor is concerned with a world there." (Heidegger, 1998: 7/7E-8/8E).

Healthcare professionals' key role in *The Omnipresence of Cancer* reflects the Existential 'Being-with' and 'Dasein-with'. By having the ability to encounter and relate to other people, the person becomes aware of herself and her own situation. For the medical care team to find time to discuss the diagnosis and treatments diminishes patients' Uncertainty and makes the cancer more manageable. Patients feel

---

[331] Also see section 3.1 of chapter 3.
[332] Confer with section 3.2 of chapter 3.

well looked after and taken seriously[333]. Human beings share the world communicating to each other in Speaking. Human existence is individual. It is not possible for a person to slip into another person's life. Every individual has her own life and experiences. Because people are different from one another, their perceptions, views, attitudes and beliefs are different. It is quite impossible that each and every individual has exactly the same outlook on life, on pertinent issues or the same goals. Sharing, however, is possible by communicating with each other. In communication people are able to disclose their Being-in-the-world to themselves and to others (Heidegger, 1998: 9/9E).

> "It is predominantly in speaking that man's being-in-the-world takes place. (. . .) In the manner in which Dasein in its world speaks about its way of dealing with its world, a self-interpretation of Dasein is also given. It states how Dasein specifically understands itself, what it takes itself to be." (Heidegger, 1998: 8/8E).

Sharing perspectives on life and experiences is beneficial. Realisation and acceptance of the Transitory nature of human existence may particularly benefit from interpersonal communication. Within medical institutions, an individual may choose to exchange views, perceptions and beliefs with doctors and nurses. In this setting, healthcare professionals form a group of people that reflects the They[334] (Heidegger, 1993a: 126ff; 1996: 164ff). From the perspective of doctors and nurses, patients also form a group and therefore represent the They. According to Heidegger (1998: 8/8E) in Speaking with other people, an individual reveals her Being-in-the-world[335]. However, Being-with other people is not always easy and straight forward. Mismatched relationships and misunderstandings may occur (Heidegger, 1998: 16/16E). Time constraints and differing perspectives in both groups may lead to misapprehensions and little regard between the two groups resulting in negative communication experiences.

---

[333] Refer to section 6.1 of chapter 6.

[334] See section 2.4 of chapter 2.

[335] Also consult section 4.2.1 of chapter 4.

The importance of communication and information, as well as imparting a diagnosis of a fatal disease is highlighted by Jaspers (1991: 557ff)[336]. Only the verbal expression allows for a thought or an idea to distinguish itself from the general mass of the unknown (Jaspers, 1991: 412). Apart from the use of language in the communication between human beings, Jaspers (1991: 557) also advocated truthfulness. Without absolute sincerity, the communication between human beings is flawed and not useful to anyone. In relation to a situation of imparting the diagnosis of a fatal illness, a medical professional assumes an important role. The physician is expected to have acquired some knowledge about the individual concerned. Therefore, the physician decides how much and what kind of information the patient needs to receive about her illness (Jaspers, 1991: 559). Hence, Jaspers (1991: 559) advocated an information policy that lies between the two extremes of telling everything truthfully and of withholding information completely. Literature also supports this belief stating that doctors and nurses are closest to the patient and therefore uniquely placed to find out what the patient really wants[337] (Brewin, 1977; Buckman, 1984; Buckman, 1989; Campbell, 1994; Sahay et al., 2000; Schwarz, 1985). Besides the medical care team, family and friends influence a patient's coping with Uncertainty. By experiencing support, be it of a material kind such as transportation or of a more emotional kind such as presence, patients feel taken care of and motivated in regaining certainty.

Regular screenings follow anti-cancer therapy. Tests establish whether the treatments have been efficient and curative. They also serve to monitor any spread of malignancy. Screenings, including the first notice of the appointment and waiting for results, involve considerable waiting and suspense that weigh heavily on the individual's mind. Until the screening results are known, the individual lives in

---

[336] Confer to section 3.1 in chapter 3.
[337] Compare to section 3.4 of the literature review in chapter 3.

limbo. Thoughts revolve around the possibility of relapse. Despite the receipt of a diagnosis of cancer, potential recurrence is a new experience. It cannot be compared to the initial confrontation with a diagnosis of colorectal cancer. In this instance, the diagnosis and primary treatments have already been lived through and are therefore known. There is an acute awareness of the disease being a permanent threat to life. Screenings force the individual to think about further potential malignant growth. Despite treatments. There is no absolute guarantee that a tumour may not reappear. This becomes a great concern. There is Uncertainty about the future. People express their Uncertainty by avoiding considering the diagnosis of cancer at length. Not acknowledging the cancer is a coping mechanism to regain certainty. Literature maintains controversial views on the effect of denial and avoidance (Faller, 1998; Klauer and Filipp, 1997; Meerwein and Stiefel, 1997: 266ff). However, there is evidence that denial and avoidance have a beneficial effect on disease management from a longitudinal perspective and belong to a normative coping process (Faller, 1998; Meerwein and Stiefel, 1997).

Relief is almost unbearable when screening results are negative. Individuals experience a state of euphoria. Good screening results offer reassurance and certainty. Regular monitoring is expected to reveal any unaccountable growth. Therefore taking action may be possible at the earliest moment. In *Mapping Out The Future* a malignancy is seen as being manageable. Such perceptions are interpreted in terms of Heidegger's Existentials Understanding, Temporality and Being-towards-death, as well as the two modes of Being, namely Authenticity and Inauthenticity[338]. An individual diagnosed with colorectal cancer experiences a complete upheaval of familiar everydayness. It is necessary to devise coping strategies to manage the dissolution of everything that is known. Reconfiguration of the individual's situation must happen making way for re-consideration of the future. Therefore a person's Under-

---

[338] See sections 2.3, 2.5, 2.6 and 2.7 of chapter 2.

standing discloses the changed situation and enables modification of the future. The disclosure of a changed situation brings the individual before herself. Authentic Dasein becomes attainable. The process happens over time, thereby introducing Temporality.

> "Coming back to itself futurally, resoluteness brings itself into the Situation by making present. The character of "having been" arises from the future, and in such a way that the future which "has been" (or better which "is in the process of having been") releases from itself the Present. This phenomenon has the unity of a future which makes present in the process of having been; we designate it as "temporality"." (Heidegger, 1993a: 326; 1996: 374).

Life is temporal and subject to time. Past, present and future are open for consideration by the person, signifying another step in regaining certainty and the reconfiguration of the future. Temporality is an expression of changing beliefs and goals or reinforcing them with the passage in time (Heidegger, 1998: 19/19E).

7.2.2. Transitoriness

Managing the Transitory nature of human existence is represented in the construct 'Transitoriness' in the sub-category, *Mapping Out The Future*. It refers to an individual's experience of coping and living with a life-threatening illness. Although death is known as the end of human existence, it becomes real and imminent through a diagnosis of colorectal cancer. The actual situation is challenged. Plans for the foreseeable future are stopped. The individual's projections for the future are questioned. As stated in *Toward Authentic Dasein*, due to the diagnosis of colorectal cancer, death is no longer a remote possibility. It becomes real and may happen sooner than originally anticipated. The fatal nature of colorectal cancer weighs heavily, provokes tiredness and a loss of motivation for life itself. Thoughts of death transcend chemotherapy and radiotherapy. Realisation of the Transitory nature of human life becomes an inherent part of individuals' everyday life to which they return after conclusion of the treatments.

Individuals are firstly concerned about communicating the fatality of the disease to families and friends. Coping strategies are developed to manage the confrontation with Transitoriness and to be empowered to discuss the cancer with family and friends. At the same time, support by family and friends promote an individual's coping process.

The interrelatedness of social support and coping has been described extensively in the literature. However, research about the effectiveness of social support remains controversial necessitating further exploration (Leppin and Schwarzer, 1997; Schröder, 1997). People's concern about their families and the reciprocal support between patients and families take up Heidegger's Existentials of Being-with and Solicitude. It is maintained that people are concerned about themselves and others, whereas the concern is not qualified to be either good or bad. However, the concernful attitude towards oneself and others may account for the interrelatedness of social support and coping mechanisms, as well as the difficulties at discussing a fatal disease within a family.

Thoughts about death may be intensified by meeting other people who have been diagnosed with cancer. Meeting other human beings who experience a similar situation affects the individual deeply. These experiences can be linked with Heidegger's Existential Being-towards-death[339].

> "The Being of possibility here always is the possibility in such a way that this possibility knows of death, for the most part in the sense that 'I already know, but am not thinking about it'. For the most part I know of death in the manner of a knowing that shrinks back. As an interpretation of Dasein, this knowing is immediately on hand to disguise the possibility of its Being. Dasein itself has the possibility of evading its death." (Heidegger, 1998: 12/12E).

Human beings are aware of the fact of death and that it signifies the end of human existence (Heidegger, 1993a: 234; 1996: 276-277; 1998: 11/11E). Death is a person's utmost and unique possibility. However, time, location and circumstances of one's

---

[339] Consult section 2.7 of chapter 2.

death are generally unknown. Being told about having colorectal cancer raises an individual's awareness of the Transitory nature of human existence. A person's view of the actual situation and outlook on the future are questioned. Thus, *Mapping Out The Future* is made possible and even becomes a necessity.

Coming to terms with the Transitory nature of human existence involves various coping strategies. Among these are denial, discussing the illness and hopeful attitudes. Individuals make use of a variety of coping strategies to achieve acceptance of the disease and allocate it a place in their lives. Conclusion of treatments promotes acceptance of the disease. It is not allowed to encroach further on an individual's life. These processes reflect a person's *Mapping Out The Future*. Returning to everydayness is facilitated and familiar routine can be envisioned again.

Here, Heidegger's perspective on the interrelationship of the individual and death are associated. The individual's end is her unique and own particular possibility. It is a human characteristic to avoid considering death (Heidegger, 1998: 12/12E). Denial, therefore, becomes a legitimate human strategy of dealing with the potentiality of death and death itself, as well as to project the future (Heidegger, 1998: 12/12E). Individuals may choose to think or not to think about their death when *Mapping Out* their *Future*. By using denial to cope with illness as a threat to life and nearing death, human beings attempt to find a way to look forward and to think about future possibilities without fear of death. In this way, a person's life can begin again.

> "Being-towards-death is grounded in care. Dasein, as thrown Being-in-the-world, has in every case already been delivered over to its death." (Heidegger, 1993 a: 259; 1996: 303).

Screenings carry the threat of the discovery of further cancerous growth. The potentiality of relapse provokes thoughts about impending demise that impacts projections of the future. In this instance, coping with the illness and its threat to life is unavoidable.

Being given a diagnosis of cancer and its impact on life offers opportunities to develop awareness about the finitude of human existence. Therefore, people consider possibilities in life and may redefine them. The choice of an individual's unique possibilities versus other less particular possibilities that are of an average kind, points to the dynamic characteristic of Authenticity. By embracing authentic Dasein, an individual chooses to think about the Transitory nature of human existence, accepting death as her own end of life. Nevertheless, Authenticity is dynamic and does not last forever. Inauthenticity is the preferred choice in everyday life (Heidegger, 1993a: 181; 1996: 167)[340]. It is the individual's choice whether she wants to think actively about the transitory nature of human life, or whether she wants to forget about it as soon as possible. Whatever individuals choose, their possibilities in life, as well as their projections of the future may undergo yet more changes.

7.2.3. Locus of Control

The third construct in *Mapping Out The Future,* although closely interrelated with Uncertainty and Transitoriness, is instrumental in the attempt to return to everyday life. Experiencing the receipt of a diagnosis of colorectal cancer and its impact on human life results in a shift of the Locus of Control from internal to external[341]. During anti-cancer treatments individuals focus on regaining an internal Locus of Control that culminates in their successful management of everyday life. Locus of Control is expressed by the degree of dependence individuals demonstrate. The diagnosis of colorectal cancer impacts on an individual's independence. With manifestation of the first symptoms, a person's independence diminishes and dependence increases. The transition from an internal Locus of Control to an external Locus of Control is experienced for some time. With control relegated to healthcare profes-

---

[340] Consult section 2.5 in chapter 2. Further reading in Gelven (1989: 50ff), King (2001: 40ff) and Solomon (1972: 210ff).

[341] Also compare sections 7.1.3 on Locus of Control.

sionals, illness rules the patients' lives. All efforts are directed toward combating the disease[342].

Towards the conclusion of primary treatments, delegation of control is questioned. Regaining an internal Locus of Control becomes important. Using alternative/complementary therapies is one way in which patients assert an internal Locus of Control and diminish their degree of dependence on healthcare professionals[343]. Participation in medical research is another area that involves independent decision making and serves to generate an internal Locus of Control. Deciding to discontinue chemotherapy - or other treatments - marks a decisive move toward regaining an internal Locus of Control. Professional support and understanding in the decision to discontinue therapies is required when patients' well-being is significantly impaired and no alternative or adaptation of treatment proves successful.

Individuals diagnosed with cancer work at removing the external Locus of Control from the medical care team to re-establish an internal Locus of Control. However, the disease continues to rule the person's life as it has assumed a central place.

Reconfiguration of an individual's Locus of Control corresponds to the interrelatedness of the two modes of Being that are Authenticity and Inauthenticity. An individual's confrontation with her own death - a diagnosis of cancer constitutes such an event - offers an opportunity to the person concerned to glimpse authentic Dasein. Therefore, the individual is brought before a choice. She can either move toward conceptualisation and realisation of her unique possibilities or move back and remain submerged as inauthentic Dasein as part of the They. Individuals' efforts at regaining an internal Locus of Control take up authentic Dasein. The protective umbrella offered by healthcare professionals is rejected. Individual well-being, thoughts and ideas become core and constitute motivations to re-establish an internal Locus of Control.

---

[342] See section 6.3 in the results and discussion chapter 6.

[343] Refer back to section 3.2 of chapter 3.

Cancer interferes heavily with and makes inroads into everyday life. A person's well-being is affected. Either there are physical problems such as nausea, vomiting and subsequent weakness, or fatigue, or there simply is no time for other activities due to the treatment schedule that must be maintained[344]. Social contacts have to be limited and future visions suspended due to difficulties in planning ahead. A patient's daily routine must be adjusted to accommodate the demands of the treatment schedule. Living some distance from hospital where treatments are dispensed necessitates travelling for varying distances[345]. Transportation must be organised, involving support from family members, friends or neighbours. Everyday life as the patient once knew it, is no longer possible. Regarding these issues, an external Locus of Control is difficult to challenge. Nevertheless, they assume an important role in demonstrating to patients the positive impact of social support. Dependence thus becomes necessary in order to discern and appreciate support from family, friends and neighbours. At the same time, these issues that are under an external Locus of Control constitute motivative elements for individuals to survive the treatments and to get on with life.

The importance of others in a person's life corresponds to Heidegger's Existentials, the They, Being-with, Dasein-with and Solicitude. For the individual to meaningfully interpret her own actual situation, encountering and engaging in communication with other people is crucial. The Self that matters to the person can thus be explored. Hence, Dasein's concern about itself and others is reflected. Concern is not estimated in terms of positive or negative values. It is neutral. However, individuals diagnosed with cancer attribute value to concerns about their view of others. Social support is considered helpful and therefore becomes a positive factor in an individual's life.

---

[344] Compare to sections 5.3 and 5.4 of chapter 5.

[345] See section 6.1 of chapter 6.

Taking up previous routines of everyday life are particularly difficult for patients who are confronted with an ileostomy or colostomy, be they temporary or permanent. Life changes dramatically, also with regard to the individual's self. Initial confrontation of an ileostomy or colostomy is "absolutely dreadful and repugnant" (S3). It invokes Fear and Anxiety. Initially, the ileostomy and colostomy is managed by nurses and demonstrates an individual's external Locus of Control. Learning to care for an ileostomy or colostomy means a significant passage in which an internal Locus of Control is regained. Managing the ileostomy or colostomy oneself, thereby re-establishing control, is a source of pride. It signifies attainment of a personal goal. Feelings of satisfaction and achievement are generated. In everydayness, however, individuals with an ileostomy or colostomy tire more easily and lack energy. Self-pity or thoughts about the illness must be fought, as they may lead to depression and dejection[346]. At the same time, the patients' everyday routine is therapeutic. Routine relegates the illness to a less prominent position in a person's life. Thoughts about cancer and its threat to life are relegated to the back of the individual's mind, reinforcing an internal Locus of Control.

In *Mapping Out The Future* an internal Locus of Control assumes a pivotal role. It corresponds to authentic Dasein. Although not attributed a significant role in Heidegger's Ontology of Dasein, the 'electric field' constituted by Authenticity and Inauthenticity is instrumental for individuals' reconfiguration of Locus of Control. This is reinforced by their impression that routine becomes a strategy for allocating the disease a place in individuals' lives. By emphasising routine, inauthentic Dasein that normally lives submerged in the They becomes predominant once more, thereby confirming Heidegger's perspective that in everydayness, Dasein's mode of Being is preferably inauthentic (Heidegger, 1993a: 181; 1996: 225).

---

[346] Consult chapter 3 in section 3.6.

Eventually for many patients an internal Locus of Control is regained. They are once more able to make their own choices. The longer treatments last, the longer a patient is confronted with cancer; the more eager she grows to regain an internal Locus of Control. This is all part of *Mapping Out The Future* and involves coping strategies developed according to the demands of the situation. Fighting the disease signifies a strong move toward an internal Locus of Control. Cancer is perceived to be an enemy that can be fought with appropriate weapons. Fighting cancer is empowering. A strategy in the fight against cancer is the coping strategy termed 'deliberate positive thinking'[347]. If individuals are convinced that the best possible is being done, it follows that the situation will improve. Negative feelings are accepted and transformed into positive experiences. Coping with the cancer and the life-threat it represents is a struggle. However, the benefit gained from new knowledge generated and accumulated by the illness situation is considered substantial. Acceptance of the illness as part of a person's life is a manifestation of internal Locus of Control. Assuming a similar position as acceptance is resignation. Acceptance is not found to be constant. Rather it alternates with resignation[348].

Demonstration of an internal Locus of Control is an assertion of one's own wishes and culminates in the patient's overall attitude regarding relapse and further treatments. Convictions regarding reactions in case of a relapse range from determined refusal of further treatment to indecisiveness, even when treatments are well tolerated. A relapse, i.e., a renewed manifestation of cancer, is perceived to be very serious and even more life-threatening than the initial diagnosis. At this point, the individual has already experienced treatment. Therefore, she has developed some knowledge about the disease process and treatment procedure. Analysis and evaluation of a relapse are influenced by the experiences acquired from initial receipt of the diagnosis, to subsequent treatment schedules and potential benefits.

---

[347] Compare with section 3.3 of the literature review. Also consult section 6.2 and 6.3 of chapter 6.
[348] See section 3.5 in chapter 3.

Experiencing a diagnosis of colorectal cancer and its impact on life is a learning experience that offers new knowledge and an expansion of personal horizon. A new basis for perceiving and evaluating the past, present and future is developed, leading to a different outlook on life. This process involves strategies such as 'deliberate positive thinking' and 'fighting'. The interrelatedness of coping strategies directed at regaining an internal Locus of Control demonstrates how *Toward Authentic Dasein* and *Mapping Out The Future* are connected within *The Omnipresence of Cancer*.

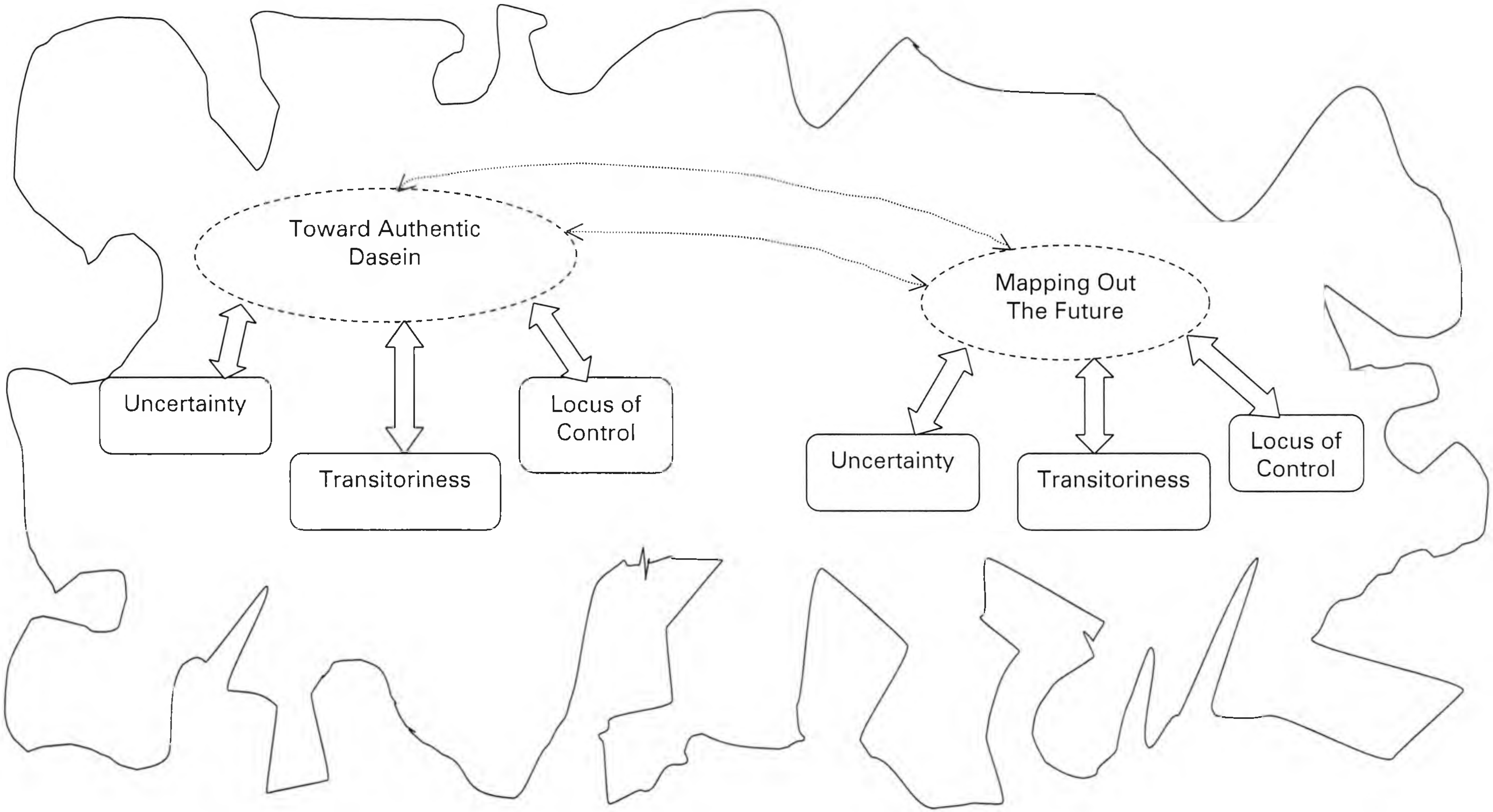
Regaining an internal Locus of Control means developing new strategies to manage what a person is experiencing. Patients have to deal with their thoughts about death or a limited life-span, health problems, family concerns and impairment of everyday life activities. Finding explanations for the cancer, speculating about its causes and development, and talking with other people are ways of dealing with the Uncertainty based on Fear and Anxiety. Transitoriness is managed by engaging in discussions with healthcare professionals and other patients in similar circumstances. Support from family, friends and other acquaintances promotes successful coping that culminates in acceptance of the illness. This state is not constant, but rather alternates with resignation at the overwhelming power of the disease. Nevertheless, an internal Locus of Control is regained, smoothing the path back into everydayness, as well as making routine a necessity.

7.2.4. Summary

Assertion of an internal Locus of Control signifies that the powers of decision making are in the 'hands' of the individuals themselves. It is up to a person to consider her choices and possibilities and to select ways for realisation. Among these choices, there is also the possibility of delegating control to others and living submerged in the They. A diagnosis of colorectal cancer eventually leads to the re-establishment of an internal Locus of Control in the person concerned. Thus, return to everyday life becomes possible and a necessity. Nevertheless, an individual diagnosed with colorectal cancer is changed. Throughout the disease process and beyond, the person experiences Uncertainty based on Fear and Anxiety, is brought before herself through realisation of the finitude of human life, and experiences a reconfiguration of Locus of Control. Therefore, Understanding and State-of-mind disclose a person's changing views, attitudes and beliefs. The basis for future conceptualisations is modified though the illness experience, changing outlook on life and future. Coping with the illness experience including the transition from an external Locus of Control to an internal Locus of Control reflects an individual's *Mapping Out The Future.*

"Cancer has been a great turning point for me. I am euphoric and have unlimited energy. In particular, the final colonoscopy and the assistance of the nurses were a complete relief and liberating." (S6)

Figure 8.1: The Theory – *The Omnipresence of Cancer*



8. Conclusion

In this final chapter, *The Omnipresence of Cancer* (see figure 8.1) will be summarised. Implications and recommendations for nursing practice, education and research will be addressed. Consideration will be given as to how healthcare professionals can relate to patients within the confines of *The Omnipresence of Cancer*; an Ontology of Dasein.

8.1. The Omnipresence of Cancer

The first illness symptoms leading to the confirmation of a diagnosis of colorectal cancer set the process of *Toward Authentic Dasein* in motion. Uncertainty based on Fear and Anxiety is provoked and nurtured by the disease. In the individual's mind, these feelings move to the forefront. Only time helps to blunt Fear and Anxiety's edges and to allocate them a less prominent place. Additional health problems that affect patients in the course of treatments serve to reinforce Uncertainty, increasing Fear and Anxiety. A diagnosis of colorectal cancer signifies a sudden confrontation with the finitude of human existence. Imminent death becomes a very real possibility. Characteristically, internal and external Locus of Control are balanced in health. However, emerging symptoms of illness and a subsequent diagnosis of colorectal cancer disrupt this balance. Patients adopt an external Locus of Control as they delegate decision making to healthcare professionals. Relying on the latter's superior knowledge an external Locus of Control is welcomed in the initial disease process. Through the course of the disease, an external Locus of Control is reinforced as anti-cancer treatments prevent a return to everydayness.

Receiving and experiencing a diagnosis of colorectal cancer is underpinned by Heidegger's Existentials of State-of-mind, Being-with including Solicitude and the They, as well as Being-towards-death[349]. In particular, the two modes of Being, namely Authenticity and Inauthenticity, as well as Anxiety as basic State-of-mind and its mode Fear play important roles in the sub-category of *Toward Authentic Dasein.* By experiencing Uncertainty, Transitoriness and a transition of control to an external locus, patients are brought before themselves. Everyday life and familiar routine are disrupted by the diagnosis of cancer and its treatments. Therefore, inauthentic Dasein and being part of the They is no longer possible. The person is brought before the choice either to consider authentic Dasein or to remain inauthentic Dasein. Whatever path an individual chooses, she has had the opportunity of glimpsing authentic Dasein, thereby inviting changes in herself. Realisation of the finitude of human existence only serves to throw Authenticity into better relief. By undergoing a transition from an internal to an external Locus of Control is an individual's way of coming to terms with authentic Dasein. Only thus the process of the second subcategory, *Mapping Out The Future*, becomes possible.

Mapping Out The Future embraces an individual's coping strategies to manage the disease and its effects, as well as finding a way back to routine. Everyday life must be adjusted to the actual situation. In order to manage successfully the impact of the cancer on life, an internal Locus of Control is once more instrumental. Various strategies are developed to cope with the impact of the disease on life. They support a well-balanced equity between internal and external Locus of Control that is characteristic of well-being. Returning to everyday life becomes an important goal supporting the move towards an internal Locus of Control. Eventually, experiencing a diagnosis of colorectal cancer leads to the regaining of an internal Locus of Control. Despite successful coping that leads to acceptance - resignation of the disease, patients eventually realise that the cancer cannot be outrun. The disease is allo-

---

[349] See sections 2.2, 2.4, and 2.7 of chapter 2.

cated a place in the individual's life, thereby reinforcing its presence as a permanent companion of the patient. Uncertainty remains. An individual, who has received and experienced the impact of a diagnosis of colorectal cancer on her life, is uncertain about the immediate future. Good health is no longer taken for granted. The Transitory nature of human existence is made evident by the possibility of the individual's impending death. Realisation of mortality not only impacts on the person herself, but also her family and friends. All must consider the possibility of death and find a way around or with it. Outlook on life and future plans must be re-evaluated. In some instances, people may be forced to adapt or change plans completely. At first glance, everyday life may appear unaltered. However, at closer look, it is revealed that the individual diagnosed with colorectal cancer has changed her attitude toward familiar routines and has started to set new priorities. Cancer has become a source of profound change by virtue of its omnipresence.

Mapping Out The Future reflects Heidegger's (1993a; 1996) Existentials of Understanding, Temporality and Authenticity as a mode of Being[350]. Through a diagnosis of cancer a person moves *Toward Authentic Dasein.* Outlook on life and future plans are challenged and may change. In the management of the disease process Temporality is core[351]. Past, present and future are inherently linked to and within Dasein. One cannot be without the other. Everything is temporal and has its place. Although over and done with and irreversible, the past continues to have an effect on the present and the future. Whatever people have experienced, impacts their attitude and beliefs in the present and the future. In this way, the past may even be re-lived to some extent or altered in the present and the future. Individuals may learn from the past and act more appropriately in a similar situation. Having already lived through a diagnosis of colorectal cancer, individuals now know what will happen in

---

[350] Refer to chapter 2, sections 2.3, 2.5 and 2.6.

[351] Also consult section 2.6 in chapter 2.

case of a relapse. They have developed coping strategies to manage the disease process. In addition, they have acquired specific knowledge about the disease. In the future, they can draw from it. Nevertheless, life after a diagnosis of cancer is different from before. The outlook on life has been impacted. Future is reconsidered and plans are adapted in some cases; goals and priorities may be reset. Everyday routine is changed and reversion to the past is not possible. Cancer is omnipresent.

8.2. Nursing Practice – Implications And Recommendations

This section is concerned with the practical implications *The Omnipresence of Cancer* has on nursing practice. At first, practical implications of *Toward Authentic Dasein* will be explored. Along with it recommendations for nursing practice will be described. Secondly, *Mapping Out The Future* and its impact on practice will be illustrated. Recommendations for improving practice will follow.

8.2.1. Toward Authentic Dasein

Patients who have received a diagnosis of colorectal cancer experience a move *Toward Authentic Dasein.* This process involves Uncertainty based on Fear and Anxiety, a confrontation with the Transitory nature of human life and a transition to an external Locus of Control. First and foremost, it is crucial that the overwhelming nature of a cancer diagnosis is grasped.

Regarding the first construct of *Toward Authentic Dasein*, i.e., Uncertainty, patients will benefit from alleviating Uncertainty. The following issues need to be addressed to relieve a patient's Uncertainty and therefore reduce Fear and Anxiety:

- Information concerning the disease and process and the treatments involved is crucial.
- Fear and Anxiety are all consuming, intensifying Uncertainty. Hence, their importance needs to be recognised.
- A cancer diagnosis disrupts everyday life, thereby throwing future plans into complete disarray, challenging their realisability.
- Illness follow-ups after conclusion of treatments in the form of screenings are highly stressful events.
- To alleviate Uncertainty in the patient and to prevent an imbalance of information, the family needs to be included throughout the disease process.
- The relationship between patient and healthcare professionals is crucial and needs to be open and built on trust.

The second construct, i.e., Transitoriness, comprises patients' confrontation with their mortality due to the cancer diagnosis. It provokes profound questioning of patient's actual situation and outlook on life. The overwhelming effect of being confronted with the Transitory nature of one's life, needs to be recognised. Fear and Anxiety are all-consuming. Recognition of this important process can happen by giving patients an opportunity to discuss their fear of life. Nurses should listen carefully to patients' expressions and create an atmosphere of trust, so that patients are enabled openly to voice their Fear and Anxiety. It is necessary that patients receive comfort in the form of physical presence and an empathic attitude by nurses. Nurses need to be aware that patients may encounter difficulties within their families when introducing the potentiality of their death. By creating an open atmosphere, nurses will enable patients not only to consider their own fear of life, but also to evaluate the family's reactions and difficulties. Ideally, nurses are able to find solutions together with the patient on how to improve the actual situation.

Thirdly, patients diagnosed with colorectal cancer experience a transition from an internal to an external Locus of Control. The transition occurs as a coping strategy, but may also be due to institutional and structural conditions present in the health-care service. To support patients in their illness situation, recognition of adopting an external Locus of Control as a coping strategy is one possibility. An external Locus of Control is expressed by referring decision making to healthcare professionals. Patients rely on nurses' suggestions. However, cementing an external Locus of Control is not helpful for a successful disease management. Therefore, nurses should endeavour to empower patients to regain an internal Locus of Control. Patients exercising an internal Locus of Control are able to make informed choices about their actual situation. Therefore, clear information is crucial, as well as nurses aiming at enabling patients to give informed consent. Equally important is nurses' recognition of the limited range of action patients experience. Constrained movement occurs in response to anti-cancer treatments. Stomas, i.e., ileostomy and colostomy, are perceived as severely handicapping a patient until its management has been mastered.

In taking the process of *Toward Authentic Dasein* into account and its impact on the individual, healthcare professionals will promote coping and fulfil the expectation of support that individuals hold.

8.2.2. Mapping Out The Future

For successful coping with a diagnosis of colorectal cancer, the patient also submits to *Mapping Out The Future.* Its primary features are coping processes and strategies. To support patients' coping nurses and other healthcare professionals need to be aware of the issues explicated below regarding the three constructs of *Mapping Out The Future.*

To reduce Uncertainty, nurses need to consider the following issues:

- Verbal and non-verbal expressions of approval and reassurance by nurses and other healthcare professionals are crucial to counter Uncertainty. Patients feel that they are taken seriously and supported in their coping.
- Open discussions are important between nurses and patients. Thus, issues of Uncertainty can be addressed.
- The concept of 'true presence' as described by Parse (1996; 1998) is crucial in order to communicate an empathic attitude toward the patient.
- Nurses need to realise that screenings are situations of high tension for patients. Information, physical and emotional supports are highly important.

Patients develop a variety of coping strategies to deal with their mortality. Among those are strategies of denial, avoidance, as well as deliberate positive thinking and hope. Nurses need to be familiar with the diversity of coping strategies and their manifestations. They need to understand their interrelatedness, in order to recognise them and to be supportive to patients. It is also important that the family is included. The family's needs regarding the patient must be taken into account and addressed by nurses. Thus, individuals' coping mechanisms are accepted and promoted.

Lastly, patients experience another transition in Locus of Control. They need to regain an internal Locus of Control in order to return to everydayness and take up familiar routines again. Only thus can outlook on life be reconsidered and the *Future Mapped Out* again. Therefore, the following issues need to be incorporated into nursing practice in order to improve care of this patient group:

- The transition toward an internal Locus of Control must be supported.
- Patients should be empowered to take back decision making responsibility regarding their personal issues and life.

- The importance of social support needs to be taken into account. Nurses must be aware that family and friends impact on patients' coping processes.
- The family's needs must be addressed.
- Nurses need to aspire to provide information that is as clear as possible.
- Screenings are highly stressful. Recognition of their importance should lead to more stringent and positive support during screenings.
- Managing stomas is a source of pride. This needs reinforcement and recognition.

By observing all these implications and recommendations, care of this patient group can be improved. Most importantly, however, is the recognition that cancer is omnipresent and can never be abandoned again.

Apart from skill-related implications and recommendations for nursing practice, structural and institutional conditions in the healthcare system need to be addressed. Despite numerous publications over more than three decades[352], there is evidence that the disclosure of a diagnosis of colorectal cancer remains a sensitive issue involving controversial opinions[353]. Therefore, the following problems need to be addressed:

- Timing and location of disclosing a diagnosis are still contentious issues in healthcare services because the medical care team works under many constraints, time limitations having the most severe impacts.
- It is crucial that healthcare professionals make use of everyday language when discussing diseases with patients.
- To improve care of cancer patients the family needs to be involved, as social support can facilitate coping (Appendix G).

---

[352] See sections 3.2, 3.3, 3.4, 3.5 and 3.6 in chapter 3.

[353] Refer to sections 5.2 and 6.1 of chapters 5 and 6 respectively.

- Information is the core to delivering care to this patient group. There is evidence that institutional information channels are in need of inspection and improvement. Patients will benefit from an interdisciplinary approach that promotes information to flow without constraints.
- Finally, reconsideration of healthcare delivery structures will enhance patients' independence and diminish an external Locus of Control.

8.3. Nursing Education – Implications And Recommendations

Care of patients diagnosed with colorectal cancer needs improvement. The areas highlighted above lead to the following two programmes for nursing education that should to be instituted at all levels and be accessible not only to nurses, but other healthcare professionals as well.

1) Information delivery and communication have been identified as being core areas in need of improvement. In a problem-based learning approach nurses will benefit from in-depth introduction into communication theories. To become better able to discuss disease-related issues with patients, nurses need to be introduced to the concept of 'true presence' as defined by Parse (1996; 1998). Thus, they will be empowered to communicate their empathy to patients and provide a platform for open discussions. In order to close the theory-practice gap, to prevent Uncertainty due to ignorance about application and to enable nurses to experience the effects of enhanced communication skills, programmes should offer skills-labs in which the theories and approaches can be exercised. By using a problem-based approach, theory and practice can be linked with minimal effort. In addition, a problem-based approach takes up the fact that nursing is an applied science.

2) *The Omnipresence of Cancer* has illustrated the complex processes occurring in individuals when confronted with a diagnosis of colorectal cancer and what it means to her life. In order to improve care of this patient group, nurses will benefit from a better understanding of patients' feelings and reactions. In a problem-based learning approach, nurses can be introduced to studies of how disease impact on a patient's life. Therefore, nurses learn to recognise the form in which patients' feelings and reactions are expressed when being diagnosed with colorectal cancer. Thus, nurses will be better able to recognise patients' needs and address them meaningfully. Ideally, nurses will analyse the situation together with the patient and thus derive methods for improvement in co-operation.

8.4. Areas of Further Research

The Omnipresence of Cancer explains what it is like to be the recipient of a diagnosis of colorectal cancer and its impact on life. Further study is required to substantiate the representativeness and the applicability of *The Omnipresence of Cancer* as a theoretical perspective to other types of healthcare problems. Presentations at conferences and informal discussion about *The Omnipresence of Cancer* with experts in oncology suggest a high representativeness and applicability of the theory to other cancer diagnoses and different settings. However, this requires substantiation through thorough quantitative empiric research.

The following assumptions derived from *The Omnipresence of Cancer* should be considered for development as empirical indicators for testing:

- *Toward Authentic Dasein* and *Mapping Out The Future* are processes experienced by human beings undergoing treatment for cancer.

- *Toward Authentic Dasein* and *Mapping Out The Future* are interrelated and influence one another.
- *Toward Authentic Dasein* and *Mapping Out The Future* are essential processes in managing *The Omnipresence of Cancer.*
- *Toward Authentic Dasein* is based on Fear and Anxiety.
- The constructs of *Toward Authentic Dasein,* namely Uncertainty, Transitoriness and Locus of Control, are interrelated and influence each other.
- *Mapping Out The Future* is based on Understanding and Being-towards-death.
- The constructs of *Mapping Out The Future,* namely Uncertainty, Transitoriness and Locus of Control, are interrelated and influence each other.
- The constructs of *Toward Authentic Dasein,* namely Uncertainty, Transitoriness and Locus of Control, are impacted by Temporality.
- The constructs of *Mapping Out The Future,* namely Uncertainty, Transitoriness and Locus of Control, are impacted by Temporality.

Further exploration of these assumptions will lead to more understanding of the experiences of patients who are diagnosed with cancer (Appendix G).

8.5. Limitations of The Study

The Da-sein of Colorectal Cancer is descriptive. It has been addressed through an empirical phenomenological approach that describes the experience of being diagnosed with colorectal cancer and its impact on life. Therefore the applicability of

The Omnipresence of Cancer must be carefully evaluated. Subsequent dissemination and further testing will promote the development of *The Omnipresence of Cancer*.

As the study was conducted in a Swiss setting, applicability can be challenged. It is unclear whether the experiences of Swiss patients being told about having colorectal cancer correspond to other patients' experiences in different contexts and countries. The qualitative paradigm allows for rich description of the phenomenon to determine representativeness of the findings (Beck, 1993). Further research in different cultures will lead to an in-depth understanding of the phenomenon cross-culturally.

Subjects in the study of *The Da-sein of Colorectal Cancer* discussed issues that were important to them. The fact that the subjects determined the course of the dialogues and the dialogue schedule is considered to be an acceptable approach to reducing socially acceptable and convenient responses. However, the freedom allowed by such an approach may foster prevarication. With a small sample size prevarication cannot be cross-checked. Only through prolonged ethnographic approaches can this issue be resolved.

During the processes of condensation and analysis, the researcher 'went native' several times. The danger of becoming too much involved in the study and not to be able to distance herself from the data sufficiently for analysis was severely underestimated by the researcher. Only with the help of the panel of experts and the research supervisor's scrutiny, was it possible to conduct the processes of condensation and analysis successfully. It was beneficial to be able to draw on expert opinion at this crucial period in the research[354].

Finally, the research design, i.e., the empirical phenomenological approach, may be critiqued. In nursing science, phenomenology has become a matter of high interest. Its holistic approach to phenomena ideally reflects the worldview of nursing science

---

[354] Confer with section 4.4. of chapter 4 and Appendix F.

in relation to issues of interest (Koch, 1995; Koch, 1996; Omery, 1983; Taylor, 1993). Literature suggests that phenomenology as a research design is thoroughly established and methods of investigation are agreed upon (Burns and Grove, 1993; Jasper, 1994; Polit and Hungler, 1993). Additionally, the frame of reference informing phenomenological research is also a matter of common agreement. However, a variety of orientations can be found, as well as many controversial opinions (Paley, 1998; Walters, 1995). Therefore, it can be argued that a 'true' phenomenological research design as such does not exist. It is dependent on the phenomenon of interest. In this instance, further exploration of phenomenological epistemology will be necessary to discern the 'true' phenomenological research approach (Appendix G).

8.6. Concluding Comments

The Omnipresence of Cancer has emerged in response to the question: "What is the Dasein of colorectal cancer?" To move *Toward Authentic Dasein*, human beings need to confront their Uncertainty, Transitoriness and reconfiguration of their Locus of Control. This reveals that individuals have a chance to catch a glimpse of their authentic Dasein. It is their decision whether to work toward Authenticity or to remain inauthentic. In returning to their previous routine, the past, present and future merge. A person's past experiences, confrontation with her Transitoriness and considerations of the future, impact on the outlook of the present. This changes the person profoundly.

Heidegger's Ontology of Dasein (1993a; 1996) provides a suitable frame of reference for investigation of the phenomenon of having been diagnosed with colorectal cancer. By drawing on Heidegger's Ontology of Dasein (1993a; 1996) as a frame of reference insight about the subjects' experience is gained[355].

Conducting research that draws on Heidegger's Ontology of Dasein (1993a; 1996) as a frame of reference, provides an opportunity for questioning and challenging familiar beliefs and attitudes. The view about humans and human existence that is explicated in Heidegger's Ontology of Dasein (1993a; 1996), offers a world-view about human existence that is profound. Heidegger's Ontology (1993a; 1996) centres *The Da-sein of Colorectal Cancer* as Omnipresent.

Hence, Heidegger's Ontology of Dasein (1993a; 1996) offers new insight of patients' experiences following the receipt of a diagnosis of colorectal cancer. Through this research, healthcare professionals can understand the meaning of the patient's experience and therefore be better able to address the patient's needs. In-depth discussions that offer patients an opportunity to discuss their feelings and experiences are welcomed. In that, the concept of 'true presence' as delineated by Parse (1996; 1998) becomes important. Nurses must be aware that *The Da-sein of Colorectal Cancer* is Omnipresent; therefore, supporting patients must be a constant concern.

---

[355] Compare to chapters 2, 5, 6 and 7 of this thesis.

References

Almendingen, K., Hofstad, B., and Vatn, M., H., (2002) "Lifestyle-related factors and colorectal cancer polyps: preliminary results from a Norwegian follow-up and intervention study." *European Journal of Cancer Preview,* 11 (2): 153-158.

Bailey, C., A., (1996) *A guide to field research.* London: Sage.

Bain, N., S., Campbell, N., C., Ritchie, L., D., *et al.*, (2002) "Striking the right balance in colorectal cancer care - a qualitative study of rural and urban patients." *Family Practice,* 19 (4): 369-374.

Baldegger, E., (2001) "Bewältigung/Coping." (pp 125-143) In: Käppeli, S., (ed.) *Pflegekonzepte - Phänomene im Erleben von Krankheit und Umfeld.* Vol. 3. Bern: Hans Huber.

Bartter, K., (ed.), (2001) *Ethical issues in advanced nursing practice.* Oxford: Butterworth Heinemann.

Beck, C., T., (1993) "Technical notes. Qualitative research: the evaluation of its credibility, fittingness, and auditability." *Western Journal of Nursing Research,* 15 (2): 263-266.

Beck, C., T., (1994) "Phenomenology: its use in nursing research." *International Journal of Nursing Studies,* 31 (6): 499-510.

Begley, C., M., (1996) "Triangulation of communication skills in qualitative research instruments." *Journal of Advanced Nursing,* 24 (4): 688-693.

Benner, P., and Wrubel, J., (eds.), (1997) *Pflege, Stress und Bewältigung; gelebte Erfahrung von Gesundheit und Krankheit.* Translated I. Erckenbrecht. Bern: Hans Huber.

Benzein, E., and Saveman, B., I., (1998) "One step towards the understanding of hope: a concept analysis." *International Journal of Nursing Studies,* 35 (6): 322-329.

Berg, D., (1998) "Managing side effects of chemotherapy for colorectal cancer." *Seminars in Oncology*, 5 (Suppl. 11): 53-59.

Biemel, W., (1996) *Heidegger*. 13th edn. Reinbeck bei Hamburg: Rowohlt Taschenbuch Verlag GmbH.

Black, P., K., and Hyde, C., (2002) "Parents with colorectal cancer: 'what do I tell the children?'" *British Journal of Nursing*, 11 (10): 679-685.

Black, P., M., and Morrow, G., R., (1991) "Anticipatory nausea and emesis: behavioural interventions." (pp 45-73) In: Watson, M., (ed.) *Cancer patient care: psychosocial treatment methods*. Cambridge: British Psychological Society.

Blanchard, C., G., Labrecque, M., S., Ruckdeschel, J., C., *et al.*, (1988) "Information and decision-making preferences of hospitalised adult cancer patients." *Social Science and Medicine*, 27 (11): 1139-1145.

Bluglass, K., (1991) "Care of the cancer patient's family." (pp 159-189) In: Watson, M., (ed.) *Cancer Patient Care: Psychosocial Treatment Methods*. Cambridge: British Psychological Society.

Bouchardy, C., Verkooijen, H., M., Chappuis, P., *et al.*, (2002) "Occurrence and impact of genetic factors in breast cancer among the female population in Geneva: creation of the Geneva Familial Breast Cancer Registry." *Schweizer Krebs Bulletin*, 22 (4): 165-168.

Bräutigam, W., and Meerwein, F., (eds.), (1985) *Das therapeutische Gespräch mit Krebskranken; Fortschritte in der Psychoonkologie*. Bern: Hans Huber.

Breaden, K., (1997) "Cancer and beyond: the question of survivorship." *Journal of Advanced Nursing*, 26 (5): 978-984.

Brewin, T., B., (1977) "The cancer patient: communication and morale." *British Medical Journal*, 2 (6103): 1623-1627.

Brink, P., J., (1991) "Issues of reliability and validity." (pp 163-186) In: Morse, J., M., (ed.) *Qualitative Nursing Research; a contemporary dialogue*. London: Sage.

Bryman, A., (1984) "The debate about quantitative and qualitative research: a question of method or epistemology?" *British Journal of Sociology*, 35 (1): 75-92.

Buckman, R., (1984) "For debate. Breaking bad news: why is it still so difficult?" *British Medical Journal*, May, 288 (6430): 1597-1599.

Buckman, R., (1989) "Communicating with cancer patients." *The Practitioner*, October, 233 (1477): 1393-1396.

Bühlmann, J., (2001) "Hoffnung/Hoffnungslosigkeit." (pp 103-118) In: Käppeli, S., (ed.) *Pflegekonzepte - Phänomene im Erleben von Krankheit und Umfeld.* Vol. 1. Bern: Hans Huber.

Bürgin, D., and Di Gallo, A., (1998) "Pädiatrische Psycho-Onkologie." (pp 143-158) In: Meerwein, F., and Bräutigam, W., (eds.) *Einführung in die Psycho-Onkologie.* 5th edn. Bern: Hans Huber.

Bui, L., L., Last, L., Bradley, H., *et al.*, (2002) "Interest and participation in support group programs among patients with colorectal cancer." *Cancer Nursing*, 25 (2): 150-157.

Burns, N., and Grove, S., K., (1993) *The practice of nursing research; conduct, critique and utilization.* 2nd edn. Philadelphia: W. B. Saunders.

Burton, M., V., (1991) "Counselling in routine care: a client-centred approach." (pp 74-93) In: Watson, M., (ed.) *Cancer Patient Care: Psychosocial Treatment Methods.* Cambridge: British Psychological Society.

Campbell, M., L., (1994) "Breaking bad news to patients." *Journal of the American Medical Association*, April, 271 (13): 1052.

Chambers, N., (1998) "We have to put up with it - don't we? The experience of being the registered nurse on duty, managing a violent indicent involving an elderly patient: a phenomenological study." *Journal of Advanced Nursing*, 27 (2): 429-436.

Clipp, E., C., and George, L., K., (1992) "Patients with cancer and their spouse caregivers. Perceptions of the illness experience." *Cancer*, 69 (4): 1074-1079.

Colaizzi, P., F., (1978) "Psychological research as the phenomenologist views it." (pp 48-71) In: Valle, R., S., and King, M., (eds.) *Existential-phenomenological alternative for psychology*. New York: Oxford University Press.

Connors, R., Smith, T., and Hickman, C., (1994) *The Oz principle; getting results through individual and organizational accountability*. Paramus: Prentice Hall.

Courneya, K., S., and Friedenreich, C., M., (1997) "Relationship between exercise pattern across the cancer experience and current quality of life in colorectal cancer survivors." *Journal of Alternative and Complementary Medicine*, Fall, 3 (3): 215-226.

Cox, C., L., and Reyes-Hughes, A., (eds.), (2001) *Clinical effectiveness in practice*. Hampshire: Palgrave.

De Boer, M., F., Ryckman, R., M., Pruyn, J., F., A., *et al.*, (1999) "Psychosocial correlates of cancer relapse and survival: a literature review." *Patient Education and Counseling*, July, 37 (3): 215-230.

De Raeve, L., (1997) "Positive thinking and moral oppression in cancer care." *European Journal of Cancer Care*, 6 (4): 249-256.

Denzin, N., K., and Lincoln, Y., S, (eds.), (1994) *Handbook of qualitative research*. London: Sage.

Denzin, N., K., and Lincoln, Y., S., (eds.), (1998) *Collecting and interpreting qualitative materials*. London: Sage.

Dibelius, O., and Arndt, M., (eds.), (2003) *Pflegemanagement zwischen Ethik und Ökonomie. Eine europäische Perspektive*. Hannover: Schlütersche.

Dillon, R., S., and Stines, P., W., (1996) "A phenomenological study of faculty-student caring interactions." *Journal of Nursing Education*, 35 (3): 113-118.

Doch, T., (1995) "Sie haben Krebs, wissen Sie das? " *Psychologie heute; das Bild des Menschen*. 22 (11): 35-40.

Dooher, J., and Byrt, R., (2002) *Empowerment and participation: power, influence and control in contemporary health care*. Vol. 1. Wiltshire: Mark Allen.

Dreyfus, H., L., (1995) *Being-in-the-world. A commentary on Heidegger's Being and Time, Division I.* London: MIT Press.

Eakes, G., G., (1993) "Chronic sorrow: a response to living with cancer." *Oncology Nursing Forum,* 20 (9): 1327-1334.

Eichholzer, M., (2001) "Die Bedeutung von Ernährung, Gewicht und Sport in der Primärprävention von Krebs." Given at: Glaus, A., and Senn, H., J., (eds.) 5. *Internationales Seminar: Onkologische Krankenpflege.* St Gallen: European School of Oncology - Deutschsprachiges Programm.

Elbirght, P., R., and Lyon, B., (2002) "Understanding hope and factors that enhance hope in women with breast cancer." *Oncology Nursing Forum,* 29 (3): 561-568.

Faller, H., (1998) *Krankheitsverarbeitung bei Krebskranken.* Göttingen: Verlag für Angewandte Psychologie.

Fallowfield, L., J., Jenkins, V., A., and Beveridge, H., A., (2002) "Truth may hurt but deceit hurts more: communication in palliative care." *Palliative Medicine,* 16 (4): 297-303.

Fielding, N., (1994) "Interviewing techniques. Varieties of research interviews." *Nurse Researcher,* 1 (3): 4-13.

Filipp, S., H., (1990) "Subjektive Theorien als Forschungsgegenstand." (pp 247-262) In: Schwarzer, R., (ed.) *Gesundheitspsychologie - Ein Lehrbuch.* Göttingen: CJ Hogrefe.

Filipp, S., H., and Aymanns, P., (1997) "Subjektive Krankheitstheorien." (pp 3-21) In: Schwarzer, R., (ed.) *Gesundheitspsychologie - Ein Lehrbuch.* 2nd edn. Göttingen: CJ Hogrefe.

Flanagan, J., and Holmes, S., (2000) "Social perceptions of cancer and their impacts: implications for nursing arising from the literature." *Journal of Advanced Nursing,* 32 (3): 740-747.

Flew, A., (ed. Consultant), (1983) *A dictionary of philosophy.* London: Pan Books Ltd.

Foucault, M., (1968) *Psychologie und Geisteskrankheit.* Frankfurt am Main: Edition Suhrkamp.

Friedemann, M., L., (1992) "Das Pflegemodell des systemischen Gleichgewichts." *Pflege,* 5 (3): 193-201.

Galloway, S., C., and Graydon, J., E., (1996) "Uncertainty, symptom distress, and information needs after surgery for cancer of the colon." *Cancer Nursing,* 19 (2): 112-117.

Gelven, M., (1989) *A commentary on Heidegger's Being and Time.* Illinois: Northern Illinois University Press.

Girgis, A., and Sanson-Fisher, R., W., (1995) "Breaking bad news: consensus guidelines for medical practitioners." *Journal of Clinical Oncology,* 13 (9): 2449-2456.

Given, B., Given, C., Azzouz, F., *et al.*, (2001) "Physical functioning of elderly cancer patients prior to diagnosis and following initial treatment." *Nursing Research,* 50 (4): 222-232.

Glaus, A., (1985) "Die Onkologieschwester." (pp 179-192) In: Meerwein, F., (ed.) *Einführung in die Psychoonkologie.* 3rd edn. Bern: Hans Huber.

Glaus, A., (1993) "Assessment of fatigue in cancer and non-cancer patients and in healthy individuals." *Supportive Care in Cancer,* 6 (1): 305-315.

Glaus, A., (1998) "Psycho-Onkologie und Pflege." (pp 171-185) In: Meerwein, F., and Bräutigam, W., (eds.) *Einführung in die Psycho-Onkologie.* 5th edn. Bern: Hans Huber.

Glaus, A., Frei, I., A., Knipping, C., *et al.*, (2002) "Schade, dass ich das nicht vorher gewusst habe! Was Krebskranke von den Informationen über Fatigue halten: eine Beurteilung durch Patienten in der Schweiz und in England." *Pflege,* 15 (5): 187-194.

Glaus, A., Jungi, W., F., and Senn, H., J., (eds.), (1997) *Onkologie für Pflegeberufe.* 5th edn. Stuttgart: Thieme.

Glaus, A., and Meier, R., (1997) "Rolle des Pflegepersonals in der Pflege Tumorkranker." (pp 218-249) In: Glaus, A., Jungi, W., F., and Senn, H., J., (eds.) *Onkologie für Pflegeberufe.* 5th edn. Stuttgart: Thieme.

Glaus, A., and Senn, H., J., (eds.), (2001) *5. Internationales Seminar: Onkologische Krankenpflege.* St Gallen: European School of Oncology - Deutschsprachiges Programm.

Glaus Hartmann, M., (1999) "Ermüdung/Erschöpfung." (pp 97-113) In: Käppeli, S., (ed.) *Pflegekonzepte - Phänomene im Erleben von Krankheit und Umfeld.* Vol. 2. Bern: Hans Huber.

Grahn, G., (1993) "Learning to cope - an intervention in cancer care." *Supportive Care in Cancer,* 5 (1). 266-271.

Grahn, G., and Johnson, J., (1990) "Learning to cope and living with cancer. Learning-needs assessment in cancer patient education." *Scandinavian Journal of Caring Sciences,* 4 (4): 173-181.

Gray, M., (1994) "Personal experience of conducting unstructured interviews." *Nurse Researcher,* 1 (3): 65-71.

Grondin, J., (2001) *Einführung in die philosophische Hermeneutik.* Darmstadt: Wissenschaftliche Buchgesellschaft.

Guba, E., G., and Lincoln, Y., S., (1985) *Naturalistic inquiry.* London: Sage.

Haase, J., E., (1987) "Components of courage in chronically ill adolescents: a phenomenological study." *Advances in Nursing Science,* 9 (2): 64-80.

Habr-Gama, A., Santino, B., de Souza, P., M., *et al.*, (1998) "Low rectal cancer: impact of radiation and chemotherapy on surgical treatments." *Diseases of the Colon & Rectum,* 41 (9): 1087-1096.

Härle, M., (2001) "Fernsehen - das Leitmedium der Gesundheitskommuni-kation?" (pp 183-194) In: Hurrelmann, K., and Leppin, A., (eds.) *Moderne Gesundheitskommunikation; vom Aufklärungsgespräch zur E-Health.* Bern: Hans Huber.

Haller, D., (1994) *Den Lebensfaden wiederfinden; Zerfall und Aufbau in der Sozialen Welt von Patientinnen und Patienten nach einer Dickdarmkrebserkrankung. Eine empirische Studie nach der Methodologie der Grounded Theory.* Bern: Schweizerische Krebsliga.

Haller, D., (2000) "Zerfall und Aufbau in der Sozialen Welt von Patientinnen und Patienten nach einer Dickdarmkrebserkrankung." (pp 81-101) In: Haller, D., (ed.) *Grounded Theory in der Pflegeforschung; professionelles Handeln unter der Lupe.* Bern: Hans Huber.

Hallett, C., (1995) "Phenomenology. Understanding the phenomenological approach to research." *Nurse Researcher,* 3 (2): 55-65.

Hallis, D., and Slone, M., (1999) "Coping strategies and locus of control as mediating variables in the relation between exposure to political life events and psychological adjustment in Israeli children." *International Journal of Stress Management,* 6 (2): 105-123.

Heidegger, M., (1993a) *Sein und Zeit.* 17th edn. Tübingen: Max Niemeyer.

Heidegger, M., (1993b) *Grundprobleme der Phänomenologie (1919/20). Gesamtausgabe. II. Abteilung Vorlesungen 1919-1944.* Vol. 58. Frankfurt am Main: Vittorio Klostermann.

Heidegger, M., (1994) *Einführung in die phänomenologische Forschung (1923/24). Gesamtausgabe. II. Abteilung Vorlesungen 1919-1944.* Vol. 17. Frankfurt am Main: Vittorio Klostermann.

Heidegger, M., (1996) *Being and Time.* Translated J. Macquarrie and E. Robinson. Oxford: Blackwell Publishers Ltd.

Heidegger, M., (1998) *The concept of time.* Translated W. McNeill. English-German edition. Oxford: Blackwell Publishers Ltd.

Helferich, C., (2000) *Geschichte der Philosophie. Von den Anfängen bis zur Gegenwart und Östliches Denken.* München: Deutscher Taschenbuchverlag.

Helman, C., G., (2001) *Culture, health and illness.* 4th edn. London: Arnold.

Henderson, M., (2000) "Honesty best for cancer patients." *The Times*, Friday, December 1, www.thetimes.co.uk. (Accessed: 01.12.00 06:44).

Hersch, J., (1990) *Karl Jaspers - eine Einführung in sein Werk*. München: R. Piper.

Hess, U., (2001) "Mini-Allotransplants: ein immuntherapeutisches Konzept gegen Lymphome, Leukämien und solide Tumoren." Given at: Glaus, A., and Senn, H., J., (eds.) 5. *Internationales Seminar: Onkologische Krankenpflege*. St Gallen: European School of Oncology - Deutschsprachiges Programm.

Hofmann, I., (1995) "Wahrheit im Umgang mit kranken Menschen." *Pflege*, 8 (4): 333-338.

Holmes, C. A., (1990) "Alternatives to natural sciences foundations for nursing." *International Journal of Nursing Studies*, 27 (3): 187-198.

Holt, J., (2000) "Exploration of the concept of hope in the Dominican Republic." *Journal of Advanced Nursing*, 32 (5): 1116-1125.

Holzer-Pruss, C., (2001) "Die Belastungen der Angehörigen." (pp 9- 45) In: Käppeli, S., (ed.) *Pflegekonzepte - Phänomene im Erleben von Krankheit und Umfeld*. Vol. 3. Bern: Hans Huber.

Hornung, R., (1984) "Interne/externe Kontrollüberzeugung und Krebsfrüherkennung." *Sozial- und Präventivmedizin*, 29 (4-5): 229-230.

Hornung, R., (1986) *Krebs: Wissen, Einstellungen und präventives Verhalten der Bevölkerung*. Bern: Hans Huber.

Hoy, A., M., (1985) "Breaking bad news to patients." *British Journal of Hospital Medicine*, 34 (2): (96-99).

Jasper, M., (1994) "Issues in phenomenology for researchers of nursing." *Journal of Advanced Nursing*, 19 (2): 309-314.

Jaspers, K., (1991) *Von der Wahrheit*. München: Piper.

Jaspers, K., (2001) *Einführung in die Philosophie. Zwölf Radiovorträge*. 23rd edn. München: Piper.

Jess., P., Christiansen, J., and Bech, P., (2002) "Quality of life after anterior resection versus abdominoperineal extirpation for rectal cancer." *Scandinavian Journal of Gastroenterology*, 37 (10): 1201-1204.

Käppeli, S., (1998) *Zwischen Leiden und Erlösung; religiöse Motive in der Leidenserfahrung von krebskranken Juden und Christen.* Bern: Hans Huber.

Kagawa-Singer, M., (1993) "Redefining health: living with cancer." *Social Science and Medicine*, 37 (3): 295-304.

Kaufmann, W., (ed.), (1989) *Existentialism. From Dostoyewski to Sartre.* New York, NY: Meridian.

Keller, M., and Müller, E., (1994) "Aufklärung und Information von Tumorpatienten." (pp 256-272) In: Margulies, A., Fellinger, K., Kroner, T., and Gaisser, A., (eds.) *Onkologische Krankenpflege.* Berlin: Springer.

Kesselring, A., (1987) *Krebs: was bedeuten Krankheit und Unterstützung für Patienten?* Basel: Recom.

King, M., (2001) *A guide to Heidegger's Being and Time.* J. Llewelyn (ed.). Albany NY: State University of New York.

Klauer, T., and Filipp, S., H., (1997) "Formen der Krankheitsbewältigung bei Krebspatienten." (pp 377-404) In: Schwarzer, R., (ed.) G*esundheitspsychologie - Ein Lehrbuch.* 2nd edn. Göttingen: CJ Hogrefe.

Koch, T., (1994) "Establishing rigour in qualitative research: the decision trail." *Journal of Advanced Nursing*, 19 (5): 976-986.

Koch, T., (1995) "Interpretive approaches in nursing research: the influence of Husserl and Heidegger." *Journal of Advanced Nursing*, 21 (5): 827-836.

Koch, T., (1996) "Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation." *Journal of Advanced Nursing*, 24 (1): 174-184.

Kralik, D., Koch, T., and Wotton, K., (1997) "Engagement and detachment: understanding patients' experiences with nursing." *Journal of Advanced Nursing*, 26 (2): 399-407.

Kübler-Ross, E., (1996) *Interviews mit Sterbenden.* Stuttgart: Kreuz Verlag.

Kunzmann, P., Burkard, F., P., and Wiedmann, F., (2001) *dtv-Atlas Philosophie.* 9th edn. München: Deutscher Taschenbuchverlag.

Kylma, J., and Vehvilainen-Julkunen, K., (1997) "Hope in nursing research: a meta-analysis of the ontological and epistemological foundations of research on hope." *Journal of Advanced Nursing,* 25 (2): 364-371.

Lalos, A., and Eisemann, M., (1999) "Social interaction and support related to mood and locus of control in cervical and endometrial cancer patients and their spouses." *Supportive Care in Cancer,* 7 (2): 75-78.

Leppin, A., and Schwarzer, R., (1997) "Sozialer Rückhalt, Krankheit und Gesundheitsverhalten." (pp 349-373) In: Schwarzer, R., (ed.) *Gesundheitspsychologie - Ein Lehrbuch.* 2nd edn. Göttingen: Hogrefe.

Lettow, S., (2001) *Die Macht der Sorge. Die philososphische Artikulation von Geschlechterverhältnissen in Heidegger's "Sein und Zeit"*. Tübingen: Edition Diskord.

Lind, S., E., DelVecchio, M-J., Seidel, *et al.*, (1989) "Telling the diagnosis of cancer." *Journal of Clinical Oncology,* May, 7 (5): 583-589.

Links, M., and Kramer, J., (1994) "Breaking bad news: realistic versus unrealistic hopes." *Supportive Care in Cancer,* 2 (2): 91-93.

Little, M., Jordens, C., F., C., Paul, K., *et al.*, (1999) "Approval and disapproval in the narratives of colorectal cancer patients and their carers." *Health: an interdisciplinary journal for the social study of health, illness and medicine,* 3 (4): 451-467.

Luckner, A., (1997) *Martin Heidegger: "Sein und Zeit". Ein einführender Kommentar.* Paderborn: Ferdinand Schöningh.

Luna-Perez, P., Rodriguez-Ramirez, S., E., De la Barrera, M., G., *et al.*, (2002) "Multivisceral resection for colon cancer." *Journal of Surgical Oncology,* 50 (2) : 100-104.

Margulies, A., Fellinger, K., Kroner, T., *et al.*, (eds.), (1994) *Onkologische Krankenpflege.* Berlin: Springer.

Markowitz, S., D., Dawson, D., M., Willis, J., *et al.*, (2002) „Focus on colon cancer." *Cancer Cell,* April, 1 (3): 233-236.

Martz, G., (1998) "Die Beziehungen zwischen Hausarzt und onkologischem Zentrum." (pp 159-169). In: Meerwein, F., and Bräutigam, W., (eds.) *Einführung in die Psycho-Onkologie.* 5th edn. Bern: Hans Huber.

McIntosh, J., (1976) "Patients' awareness and desire for information about diagnosed but undisclosed malignant disease." *The Lancet,* August 2 (7980): 300-303.

Meerwein, F., (ed.), (1985a) *Einführung in die Psychoonkologie.* 3rd edn. Bern: Hans Huber.

Meerwein, F., (1985b) "Das Erstgespräch auf der Abteilung für medizinische Onkologie." (pp 41-66) In: Bräutigam, W., and Meerwein, F., (eds.) *Das therapeutische Gespräch mit Krebskranken; Fortschritte in der Psychoonkologie.* Bern: Hans Huber.

Meerwein, F., (1998) "Die Arzt-Patienten-Beziehung des Krebskranken." (pp 63-142) In: Meerwein, F., and Bräutigam, W., (eds.) *Einführung in die Psycho-Onkologie.* 5th edn. Bern: Hans Huber.

Meerwein, F., and Bräutigam, W., (eds.), (1998) *Einführung in die Psycho-Onkologie.* 5th edn. Bern: Hans Huber.

Meerwein, F., and Stiefel, F., (1997) "Psyche des Krebskranken." (pp 264-274) In: Glaus, A., Jungi, W., F., and Senn, H., J., (eds.) *Onkologie für Pflegeberufe.* 5th edn. Stuttgart: Thieme.

Miles, M., B., and Huberman, A., M., (1994) *Qualitative data analysis; an expanded sourcebook.* 2nd edn. London: Sage.

Miller, S., M., (1995) "Monitoring versus blunting styles of coping with cancer influence the information patients want and need about their disease. Implications for cancer screening and management." *Cancer,* 76 (2): 167-177.

Mishel, M., H., (1981) "The measurement of uncertainty in illness." *Nursing Research*, 30 (5): 258-263.

Morton, R., (1996) "Breaking bad news to patients with cancer." *Professional Nurse*, 11 (10): 669-671.

Mulhall, S., (1996) Routledge philosophy guidebook to: *Heidegger and Being and Time*. London: Routledge.

Nettleton, S., and Gustafsson, U., (eds.), (2002) *The sociology of health and illness reader*. Cambridge: Polity.

Nordin, K., and Glimelius, B., (1997) "Psychological reactions in newly diagnosed gastrointestinal cancer patients." *Acta Oncologica*, 36 (8): 803-810.

Northouse, L., L., Mood, D., Templin, T., *et al.*, (2000) "Couples' patterns of adjustment to colon cancer." *Social Science and Medicine*, 50 (2): 271-284.

Norum, J., (1998) "Quality of life in colorectal cancer patients treated with doxorubicin and a multidrug resistance (MDR) modulator (SDZ PSC-833): a pilot study." *Anticancer Research*, Juli, 18 (4 C) : 2933-2936.

Oiler, C., (1981) "The phenomenological approach in nursing research." *Nursing Research*, 31 (3): 178-181.

Omery, A., (1983) "Phenomenology: a method for nursing research." *Advances in Nursing Science*, 5 (2): 49-63.

Paley, J., (1998) "Misinterpretive phenomenology: Heidegger, ontology and nursing research." *Journal of Advanced Nursing*, 27 (4): 817-824.

Parse, R., R., (1996) "The human becoming theory: challenges in practice and research." *Nursing Science Quarterly*, 9 (2): 55-60.

Parse, R., R., (1998) *The human becoming school of thought; a perspective for nurses and other health professionals*. London: Sage.

Pestalozzi, B., C., (2000) "Vom Umgang mit dem Unumgänglichen." *Neue Zürcher Zeitung*, Samstag-Sonntag, Januar 8/9, 221 (6): 93-94.

Petersen, A., and Bunton, R., (eds.), (1997) *Foucault, health and medicine.* Foreword by B. S. Turner. London: Routledge.

Petersen, A., and Waddell, C. (eds.), (1999) *Health matters, a sociology of illness, prevention and care.* Oxford: Open University.

Phipps, S., A., A., (1993) "A phenomenological study of couples' infertility: gender influence." *Holistic Nursing Practice,* 7 (2): 44-56.

Plager, K., A., (1994) "Hermeneutic phenomenology: a methodology for family health and health promotion study in nursing." (pp 65-83) In: Benner, P., (ed.) *Interpretive phenomenology: embodiment, caring and ethics in health and illness.* London: Sage.

Polkinghorne, D., E., (1989) "Phenomenological research methods." (pp 41-60) In: Valle, R., S., and Halling, S., (eds.) *Existential-phenomenological perspectives in psychology; exploring the breadth of human experience; with a special section on transpersonal psychology.* London: Plenum.

Polit, D., F., and Hungler, B. P., (1993) *Essentials of nursing research; methods, appraisal, and utilization.* Philadelphia: J. B. Lippincott.

Porrett, T., and Daniel, N., (eds.), (1999) *Essential coloproctology for nurses.* London: Whurr Publishers Ltd.

Ptacek, J., T., Fries, E., A., Eberhardt, T., L., *et al.*, (1999) "Breaking bad news to patients: physicians' perceptions of the process." *Supportive Care in Cancer,* 7 (3): 113-120.

Radley, A., (2002) "Portrayals of suffering: on looking away, looking at and the comprehension of illness experience." *Body & Society,* 8 (3): 1-23.

Ramsey, S., D., Andersen, M., R., Etzioni, R., *et al.*, (2000) "Quality of life in survivors of colorectal carcinoma." *Cancer,* 88 (6): 1294-1303.

Rather, M., (1992) "Nursing as a way of thinking. The Heideggerian hermeneutical analysis of the lived experience of the returning RN." *Research in Nursing & Health,* 15 (1): 47-55.

Ream, E., and Richardson, A., (1999) "From theory to practice: designing interventions to reduce fatigue in patients with cancer." *Oncology Nursing Forum,* 26 (8): 1295-1305.

Redmond, K., (ed.), (2000) *Kolorektales Karzinom - Ein Leitfaden für das Pflegepersonal; NICCI: Nursing in Colorectal Cancer Initiative.* Dublin: Astra-Zeneca UK Limited & European Oncology Nursing Society.

Reinacher-Schick, A., and Schmiegel, W., (2002) "Surveillance strategies in patients after polypectomy." *Digestive Diseases,* 20 (1): 61-69.

Rose, K., (1994) "Interviewing techniques. Unstructured and semi-structured interviewing." *Nurse Researcher,* 1 (3): 23-32.

Saddler, D., A. and Ellis, C., (1999) "Colorectal cancer." *Seminary in Oncology Nursing,* 15 (1): 58-69.

Sahay, T., B., Gray, R., E., and Fitch, M., (2000) "A qualitative study of patient perspectives on colorectal cancer." *Cancer Practice,* 8 (1): 38-44.

Saleh, U., S., and Brockopp, D., Y., (2001) "Hope among patients with cancer hospitalised for bone marrow transplantation: a phenomenologic study." *Cancer Nursing,* 24 (4): 308-314.

Sandelowski, M., (1986) "The problem of rigor in qualitative research." *Advances in Nursing Science,* 8 (3): 27-37.

Sandelowski, M., (1993) "Theory unmasked: the uses and guises of theory in qualitative research." *Research in Nursing & Health,* 16 (3): 213-218.

Saner, H., (1991) *Karl Jaspers; Rowohlts Monographien.* Reinbek bei Hamburg: Rowohlt.

Schröder, K., (1997) "Persönlichkeit, Ressourcen und Bewältigung." (pp 319-347) In: Schwarzer, R., (ed.) *Gesundheitspsychologie - Ein Lehrbuch.* 2nd edn. Bern: Hogrefe.

Schulte, A., (2002) "Consensus versus disagreement in disease-related stigma: a comparison of reactions to AIDS and cancer patients." *Sociological Perspectives,* 45 (1): 81-104.

Schwarz, R., (1985) "Aufklärung über die Tumordiagnose und Vorwissen bei Patientinnen unter Brustkrebsverdacht." (pp 81-90) In: Bräutigam, W., and Meerwein, F., (ed.) *Das therapeutische Gespräch mit Krebskranken; Fortschritte in der Psychoonkologie*. Bern: Hans Huber.

Schwarz, R., (1998) "Psychosoziale Einflüsse auf die Krebsentstehung." (pp 15-48) In: Meerwein, F., and Bräutigam, W., (eds.) *Einführung in die Psychoonkologie.* 5th edn. Bern: Hans Huber.

Schwarz, R., and Hornburg, E., (1994) "Bewältigungsstrategien (Coping) bei Tumorerkrankungen." (pp 219-229) In: Margulies, A., Fellinger, K., Kroner, T., and Gaisser, A., (ed.) *Onkologische Krankenpflege*. Berlin: Springer.

Schwarzer, R., (ed.), (1997) *Gesundheitspsychologie - Ein Lehrbuch.* 2nd edn. Bern: Hogrefe.

Selvachandran, S., N., Hodder, R., J., Ballal, M., S., *et al.*, (2002) "Prediction of colorectal cancer by a patient consultation questionnaire and scoring system: a prospective study." *Lancet*, 360 (9329): 278-283.

Semmens, J., B., Platell, C., Threlfall, T., J., *et al.*, (2000) "A population-based study of the incidence, mortality and outcomes in patients following surgery for colorectal cancer in Western Australia." *Australian and New Zealand Journal of Surgery*, January, 70 (1): 11-18.

Senn, H., J., (1985) "Wahrhaftigkeit am Krankenbett." (pp 59-74) In: Meerwein, F., (ed.) *Einführung in die Psychoonkologie.* 3rd edn. Bern: Hans Huber.

Senn, H., J., (1997a) "Einführung in die Onkologie." (pp 2-19). In: Glaus, A., Jungi, W., F., and Senn, H., J. (eds.) *Onkologie für Pflegeberufe.* 5th edn. Stuttgart: Thieme.

Senn, H., J., (1997b) "Wahrhaftigkeit am Krankenbett bei Tumorpatienten." (pp 250-262) In: Glaus, A., Jungi, W., F., and Senn, H., J. (eds.) *Onkologie für Pflegeberufe.* 5th edn. Stuttgart: Thieme.

Senn, H., J., and Glaus A., (1998) "Wahrhaftigkeit am Krankenbett auch bei Tumorkranken?" (pp 49-61) In: Meerwein, F., and Bräutigam, W., (eds.) *Einführung in die Psychoonkologie.* 5th edn. Bern: Hans Huber.

Shaha, M., (2000a) "The Dasein of colorectal cancer. An ontological study." Given at: *Second European Nursing Theory Conference in Scandinavia,* 18-20 May, 2000. Stockholm: Swedish National Society for Nursing Theories in Practice, Education and Research.

Shaha, M., (2000b) "Das Dasein mit Darmkrebs. Eine ontologische Studie." Given at: *Workshop zu 'Wissenschaftlichen Konzepten der onkologischen Pflege',* 7-8 December, 2000. Wittenberg: Universität Halle-Wittenberg.

Shaha, M., (2001) "Das Dasein mit Darmkrebs. Eine ontologische Studie." Given at: Glaus, A., and Senn, H., J., (eds.) *5. Internationales Seminar: Onkologische Krankenpflege.* St Gallen: European School of Oncology - Deutschsprachiges Programm.

Shaha, M., (2002) "The Omnipresence of Cancer." (pp 130-137) In: Cox, C., (ed.), *Enhancing the practice experience. A collection of papers. European Honour Society 2002.* Bournemouth: Nursing Praxis International.

Shaha, M., and Cox, C., L., (2001) "The Dasein of colorectal cancer. An ontological study." (pp 128-135) In: Willman, A., and Nilsson, R., (eds.) *Monograph No. 10. Critical appraisal - nursing theories in practice, education and research.* Second European Nursing Theory Conference in Scandinavia, 18-20 May, 2000. Stockholm: Förlagshuset Gothia.

Shaha, M., and Cox, C., L., (2003) "The omnipresence of cancer." Submitted to the *European Journal of Oncology Nursing EJON02/022.* In press.

Shelton, B., K., (2002) "Introduction to colorectal cancer." *Seminary of Oncology Nursing*, 18 (2 Supplement 2): 2-12.

Slevin, M. L., (1987) "Talking about cancer: how much is too much?" *British Journal of Hospital Medicine*, 38 (1): 56-59.

Slevin, M., L., Nichols, S., E., Downer, S., M., *et al.*, (1996) "Emotional support for cancer patients: what do patients really want?" *British Journal of Cancer*, 74 (8): 1275-1279.

Solomon, R., C., (1972) *From rationalism to existentialism. The existentialists and their nineteenth-century backgrounds.* Lanham MD: Rowman and Littlefield.

Sorrell, J., M., and Redmond, G., M., (1995) "Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies." *Journal of Advanced Nursing*, 21 (6): 1117-1122.

Sowell, R., L., Bramlett, M., H., Gueldner, S., H., *et al.*, (1991) "The lived experience of survivial and bereavement following death of a lover from AIDS." *IMAGE, the Journal of Nursing Scholarship*, 23 (2): 89-94.

Späti, B., and Fust, R., (1997) "Gastrointestinale Tumoren." (pp 360-377) In: Glaus, A., Jungi, W., F., and Senn, H., J. (eds.) *Onkologie für Pflegeberufe.* 5th edn. Stuttgart: Thieme.

Stiggelbout, A., M., de Haes, J., C., Vree, R., *et al.*, (1997) "Follow-up of colorectal cancer patients: quality of life and attitudes towards follow-up." *British Journal of Cancer*, 75 (6): 914-920.

Strauss, A., and Corbin, J., (1998) *Basics of qualitative research. Techniques and procedures for developing grounded theory.* 2nd edn. London: Sage.

Taureck, B., H., F., (2001) *Michel Foucault.* 2nd edn. Reinbek bei Hamburg: RoRoRo Rowohlt.

Taylor, B., (1993) "Phenomenology: one way to understand nursing practice." *International Journal of Nursing Studies*, 30 (2): 171-179.

Thoman, W., and Egg, R., (1985) *Psychotherapie.* Vol. 2. Stuttgart: Kohlhammer.

Tschudin, V., (1990) *Helfen im Gespräch. Eine Anleitung für Pflegepersonen.* Basel: Recom.

Valle, R., S., and Halling, S., (eds.), (1989) *Existential-phenomenological perspectives in psychology; exploring the breadth of human experience; with a special section on transpersonal psychology.* New York: Plenum.

Walker, A., R., Walker, B., F., and Segal, I., (1993) "Can the risk of colon cancer be lessened?" *Digestive Diseases,* 11 (6): 325-333.

Walters, A., J., (1995) "The phenomenological movement: implications for nursing research." *Journal of Advanced Nursing,* 22 (4): 791-799.

Watson, M., (1991) "Breast cancer." (pp 220-237) In: Watson, M., (ed.) *Cancer patient care: psychosocial treatment methods.* Cambridge: British Psychological Society.

Weiss, E., G., and Johnson, T., E., (1999) "Colorectal cancer." (pp 97-118). In: Porrett, T., and Daniel, N., (eds.) *Essential coloproctology for nurses.* London: Whurr Publishers Ltd.

Wong, N., Y., Nenny, S., Guy, R., J., *et al.*, (2002) "Adults in a high-risk area are unaware of the importance of colorectal cancer: a telephone and mail survey." *Diseases of the Colon and Rectum,* 45 (7): 951-954.

Appendices

A. Letter to Healthcare Professionals

Understanding What A Diagnosis of Cancer Means To Patients.

Healthcare Professionals Information Sheet

I am a doctoral student in nursing at City University - St Bartholomew School of Nursing and Midwifery, London. In partial fulfilment of my degree requirements, I am undertaking this study which has the approval of the hospital management of the Spital Limmattal, Urdorferstrasse 100, CH-8952 Schlieren; of the Ethic Committee of the Cantonal Hospital in Aarau, CH-5000 Aarau, and its surgical department; of the management of the Stadtspital Waid, Tièchestrasse 60, CH-8037 Zürich; and the City University.

Cancer is one of the most common and wide-spread illnesses today. It is a disease process that has been an extensive field of research interest (Burton, 1991; Haller, 1994; Margulies et al., 1994; Benner and Wrubel, 1997). Areas of research which have not been fully explored can be identified as gaps in the literature. The experience of receiving a diagnosis of cancer and what this means to the patient's future life, is one such area.

The information below will explain the study, how it will be conducted, and what your contributions might be. It is important that you understand, what I am doing. Please, be sure to ask any questions you have about the information which follows. I will do my best to explain and provide further information.

I would like to understand how patients feel, when they are told a diagnosis of colon-cancer, what this means to them and for their future lives. The participating patients will be interviewed regularly several times by me over twelve months. The first interview will be conducted, as soon as the patients have consented to participate in the study. All interviews will be tape-recorded and transcribed. The participants have been informed of the purpose and the nature of the study. They need to fill out the consent form, of which they will receive a copy. It is for the participants to decide, when and where the interviews will be conducted. Whether or not patients agree to participate is entirely their own decision. They are free to withdraw from the study at any point. In this case, none of the collected data will be included in the study, and it will be destroyed. **Not participating or withdrawing from the study will not impact their care or medical treatment.**

To gain access to the potential participants, I will first contact the senior staff nurses and the senior consultants. The senior consultants will be asked to fill in the consent form for the physicians, of which they will receive a copy. Before contacting the potential participants, I will be approaching the nurses caring for the potential participants. Only then will I approach the patients themselves.

The participants may become distressed by talking about their illness. Naturally, I am prepared for further talks. Should it become necessary, and should the participant wish, I will inform the consultants and the nurses. If the patients do not want to take part anymore, they will be released from the study without any repercussions.

The study is strictly confidential. There will be no identification of the participants in the study. Only the supervisor, the expert panel and I myself will have access to the interview data. All records of participating patients will be kept in a bank-safe for 5 years after the conclusion of the study, unless their destruction is requested.

Potential participants may approach you to inform you of their decision either to participate or withdraw. Please, forward any information concerning the study to me directly, so that I may take appropriate action. Thank you.

Further information can be gained by contacting me:

Principal Investigator: Maya Shaha, MSc., Obere Dorfstrasse 12, CH-5034 Suhr, 062/8422846

References:

Benner, P., and Wrubel, J., (1997) *Pflege, Stress und Bewältigung. Gelebte Erfahrung von Gesundheit und Krankheit.* Aus dem Amerikanischen von I. Erckenbrecht. Bern: Hans Huber.

Burton, M., V., (1991) "Counselling in routine care: a client centred approach." In: Watson, M., (ed.), (1991) *Cancer patient care: psychosocial treatment methods.* Cambridge: Cambridge University Press and BPS (British Psychological Society) Books.

Haller, D., (1994) *Den Lebensfaden wiederfinden. Zerfall und Aufbau der sozialen Welt von Patientinnen und Patienten nach einer Dickdarmkrebserkrankung.* Bern: Schweizerische Krebsliga.

Margulies, A., Fellinger, K., Kroner, T., and Gaisser, A., (eds.), (1994) *Onkologische Krankenpflege.* Berlin: Springer.

B. Consultants' Form of Consent

Title of Research Project:

A Diagnosis of Cancer.

Name of the senior consultant: . . . .

Address: Spital Limmattal, Urdorferstrasse 100, CH-8952 Schlieren

Cantonal Hospital, CH-5000 Aarau

Stadtspital Waid, Tièchestrasse 69, CH-8037 Zürich

I have received and read the information on the study. I am asked to give my permission for Mr . . ./Mrs . . . to participate in this study. The purpose of this study is to understand, how Mr . . ./Mrs . . . felt, when he/she was told the diagnosis of colorectal cancer, what that means to him/her and for his/her future life.

I have been informed that all information gained during this study is strictly confidential and that only Ms Shaha, her supervisor, and the expert panel will have access to it. I have had the opportunity to discuss the details and ask questions about the study.

I hereby give my consent for Mr . . . /Mrs . . . to participate in the study.

SENIOR CONSULTANT'S NAME (BLOCK CAPITALS): . . . .

SENIOR CONSULTANT'S SIGNATURE: . . . .

LOCATION/DATE: . . . .

As the doctoral student responsible for the study, I confirm that I have explained to the senior consultant named above the nature and purpose of the study to be undertaken.

MS MAYA SHAHA: . . . .

MS SHAHA'S SIGNATURE: . . . .

LOCATION/DATE: . . . .

C. Letter to the Subjects.

A Diagnosis of Cancer - Invitation to Participate in a Nursing Study

Dear Mrs/Dear Mr. . . . .

This letter will provide you with information about a research project that I am undertaking as part of my doctoral studies at City University - St Bartholomew School of Nursing and Midwifery, London. I invite you to take part in this study, which has been accepted by the management of the Spital Limmattal, Urdorferstrasse 100, CH-8952 Schlieren; by the Ethic Committee of the Cantonal Hospital in Aarau, CH-5000 Aarau, and its surgical department; by the management of the Stadtspital Waid, Tièchestrasse 60, CH-8037 Zürich; and by City University. The following information explains the nature and the purpose of the study to you. It details what happens when you decide to take part. Please, make sure you understand the information before you agree to take part. This is very important. Whether or not you decide to participate is entirely your own choice. Please ask any questions you want about the study. I will do my best to answer them.

The aim of this study is to find out, how you felt, when you were told, you had colorectal cancer; and what this meant to you and for your future life. If you decide to participate, I will interview you several times regularly during a period of twelve months. The first interview will be conducted after you have agreed to participate. The interviews will be tape-recorded, and subsequently transcribed as a coherent text. Anonymity is assured.

This study is strictly confidential. There will be no identification of your name. The records of your participation in the study will be kept for 5 years after the conclusion of the study, unless you wish their destruction immediately. Only my supervisor, the expert panel and I will have access to the interview data.

It is important that you understand that you might become distressed and sad, when talking about your illness. Naturally I am prepared for further talks with you. Should it become necessary and you wish it, I will involve the consultants and nurses. You are welcome to discuss the study with your family and/or friends.

Should you decide to leave the study at any point, your decision will be accepted fully. Leaving the study will be without any repercussions. You do not need to provide any reason for withdrawing. Just inform me of your decision. Data collected until that point will be destroyed and not used in the study. **Not participating or withdrawing from the study will not affect the course of your ordinary medical care.**

When you have decided to take part, you need to fill in the attached consent form. Please read it through carefully. Thank you. If you are worried or wish to discuss the project further, you can speak to:

Ms Maya Shaha, MSc., Principal investigator, Obere Dorfstrasse 12, CH-5034 Suhr,
062/8422846.

D. Subjects' Form of Consent

No: . .

Title of Research Project:

A Diagnosis of Cancer - A Nursing Study

Name of Patient: . . . .

Address: . . . .

. . . .

. . . .

I have received and read the information on the nursing study, in which I have been asked to participate. I have had the opportunity to discuss the details and ask questions about the study.

Ms Shaha has explained the nature and the purpose of the study. I believe that I understand what is being proposed. Ms Shaha is going to ask me, how I felt, when I was told the diagnosis of my illness, what this meant to me and for my future life. This study has been accepted by the management of the Spital Limmattal, Urdorferstrasse 100, CH-8952 Schlieren; by the Ethic Committee of the Cantonal Hospital in Aarau, CH-5000 Aarau, and its surgical department; by the management of the Stadtspital Waid, Tièchestrasse 60, CH-8037 Zürich; and by City University.

I have been informed that all information gained during this study is strictly confidential and that only the supervisors, the expert panel and Ms Shaha herself will have access to it.

I hereby give my consent to participate in the study. I am aware that if I wish to leave the study at any time, I am free to do so and that my subsequent medical treatment will not be affected as a result.

PARTICIPANT'S NAME (BLOCK CAPITALS): . . . .

PARTICIPANT'S SIGNATURE: . . . .

LOCATION/DATE: . . . .

As the doctoral student responsible for this study, I confirm that I have explained to the patient named above the nature and purpose of the study to be undertaken.

MS MAYA SHAHA: . . . .

MS SHAHA'S SIGNATURE: . . . .

LOCATION/DATE: . . . .

E. Subjects' List

Subject No	Gender	Age	Diagnosis
1	Male	1921 - 2001	Carcinoma of the sigmoid colon.
2	Male	1935 - 2001	Carcinoma of the rectum T4, ileostomy
3	Female	1932	Obstructing adeno-carcinoma of the sigmoid colon, 20 cm ab ano, ileostomy
4	Male	1939	Carcinoma of the rectum, preoperative chemotherapy and radiotherapy, laparascopic rectum resection and amputation, left colostomy.
5	Female	1937	Tubulovillose carcinoma of the rectum, 10-12 cm ab ano, uT1 N0, low anterior resection, ileostomy for relief
6	Female	1933	Carcinoma of the sigmoid colon, anterior resection.
7	Male	1952	Adeno-carcinoma of the sigmoid colon, poorly differentiated 30 cm ab ano.

F. The Panel of Experts

To enhance credibility of the study, an expert panel was assembled in Switzerland. Below, each of the experts will be briefly introduced. Subsequently their contribution to the data analysis and completion of the study will be delineated.

Mrs Barbara Steiger, PRO SENECTUTE Kanton Zürich, Forchstrasse 145, CH-8032 Zürich. Qualifications: General Nurse, Health Visitor, Adult Educator of Pedagogy AEB. Worked for a two and a half years with cancer out-patients and in-patients in the Out-Patients Department of the University Hospital in Zürich.

Mrs Lisa Marxt-Mayr, Schaffhauserstrasse 126, CH-8057 Zürich. Qualifications: General Nurse, Student of Psychology. Works on a surgical unit at the University Hospital in Zürich.

Dr Agnes Glaus, Zentrum für Tumordiagnostik und Prävention, Rorschacherstrasse 150, CH-9006 St. Gallen. General Nurse, Health Visitor, PhD in Oncology at Guildford University. Has been working in Oncology for a very long time. Publications in cancer care.

Prior to the start of data collection the research proposal with the developed methods had been sent out to the experts. They were asked to evaluate critically the proposed study and convey any suggestions to the researcher.

At the end of September 1998 two experts had sent back their comments on the research proposal. One of them corrected the brief description of her professional career. The study was considered to be very interesting. A number of re-considerations were suggested regarding the rationale for the study and its potential outcome, as well as the dialogue schedule. Another expert commented on the lack of demographic information about the target population. Sampling procedures were critically evaluated.

The meeting with the supervisor in November 1998 helped the researcher to understand better implications of phenomenological research. Changes suggested by the panel of experts were considered to enhance the researcher's understanding of the phenomenological approach. However, changes in the research proposal were not considered to be necessary. The lacks of changes in the research proposal were discussed once again with the panel of experts who was able to accept the researcher's propositions.

The panel of experts was then asked to review and evaluate the analysis critically. By drawing on the experts at this stage, credibility and applicability were enhanced, and auditability was established (Guba and Lincoln, 1985; Beck, 1993). The panel requested that the researcher present the experts with the analysis of one participant throughout the study to present them with a sound basis for determining credibility. They would also be able better to follow the decision making process.

However, during the analysis the researcher presented the experts with transcripts and condensed material of four subjects. The reason for not adhering to the original resolution was to provide the experts with a very thorough overview of the data collection. As the researcher feared that the condensation process would destroy the holistic and rich description of the subjects' experiences, the experts were asked to sample at random and to forward any comments about the condensation. All three experts commented on the large amount of data. They approved of the condensation process and also appreciated the thorough overview of the study.

The approval of the condensation process motivated the researcher to proceed with analysis of the data. Colaizzi's analytical process as described by Haase (1987) was used. To confirm the analytical process and to evaluate, whether the researcher had stayed true to the subjects' views, the essential structure - the end product of the analytical process - was once again sent to the panel of experts for review. All of them approved of the essential structure, which was represented in the form of a story[356]. At this point, the direct involvement of the expert panel concluded. They will be presented with a copy of the final approved version of the thesis.

---

[356] The story is to be found at the beginning of the thesis on pages 14ff.

G. Mapping Out My Future

In the concluding chapter of this thesis, recommendations have been made in relation to further research associated with specific assumptions and empirical indicators in the middle range theory *The Omnipresence of Cancer.* In my present post at the School of Nursing in Freiburg, Switzerland, I am responsible for taking forward collaborative nursing research within the German section of research and development. This post, therefore, provides an opportunity to make a significant contribution to extending the evidence base for nursing practice in Switzerland. During the process of writing-up the thesis; in particular constructing *The Omnipresence of Cancer*, specific plans for the future emerged. In this appendix, these plans are delineated.

The Omnipresence of Cancer offers an insight into patients' experiences of having received a diagnosis of colorectal cancer and what this means to them. Informal discussions with patients suffering from other forms of cancers, as well as discussions with fellow nurse scientists in practice, education and research, suggests that *The Omnipresence of Cancer* may have relevance in relation to patients with other forms of cancer. Therefore, it is necessary to test the theory to discover its applicability. Some areas worthy of consideration include the following:

- Discerning whether there is an association of the constructs, Uncertainty, Transitoriness and Locus of Control in Toward Authentic Dasein and Mapping Out The Future, amongst patients with other forms of cancer (Refer to results and discussion chapters five and six).
- Determining, more definitively, how doctors and nurses can work with cancer patients to help them exercise their Locus of Control (Refer to page 124).
- Investigating the effect of healthcare professionals' expressions of consideration on cancer patients (Refer to page 140).
- Investigating the impact of screenings on patients diagnosed with cancer (Refer to page 140-141).
- Discerning, more thoroughly, how emotional support provided by families affects patients suffering with cancer (Refer to page 148).
- Discovering how various levels of social support impact the patient's coping process and decision-making (Refer to page 157).

In the process of developing the theory, *The Omnipresence of Cancer*, it became apparent that current healthcare delivery systems require re-engineering to improve services. In Switzerland, Bouchardy et al. (2002) have developed the Geneva Familial Breast Cancer Registry. The registry was developed from registries that compiled information about breast cancer patients from various sources. The Geneva Familial Breast Cancer Registry (Bouchardy et al., 2002) provides varied, accurate data for cohort studies that can inform decision making in relation to improving the delivery of services.

I believe that the institution of a colorectal cancer registry is necessary in order to institute best practice and improve healthcare services for colorectal cancer patients. A colorectal cancer registry would provide a wide data base that could facilitate research amongst the colorectal cancer patient population. I am suggesting that a registry is situated at one of the Cantonal hospitals be enlarged to include all patients in Switzerland. This would provide a substantial data base for cohort studies that would inform decision making in relation to improving the delivery of services for colorectal cancer patients.

Reference:

Bouchardy, C., Verkooijen, H., M., Chappuis, P., *et al.*, (2002) "Occurrence and impact of genetic factors in breast cancer among the female population in Geneva: creation of the Geneva Familial Breast Cancer Registry." *Schweizer Krebsbulletin*, 22 (4): 165-168.

H. Publications

During this study and the writing-up process, I have published the following papers on the subject. As they are requested to be compiled for the submission of the thesis, they are included in this appendix.

Publication 1

A paper presented at the Second International Scandinavian Nursing Theory Conference in Stockholm/Sweden. From the 18th to the 20th of May 2000. Subsequent publication in the conference proceedings.

Title:

The Dasein of Colorectal Cancer. An Ontological Study.

Author:

Maya Shaha
Schwirrenmattweg 12 C
CH-5034 Suhr
Switzerland

Supervisor:

Dr Carol Cox
City University - St Bartholomew School of Nursing and Midwifery
London EC1A 7QN

Abstract

The on-going study, *The Dasein of Colorectal Cancer*, intends to describe the lived experience of being told about having colorectal cancer and its meaning for the future life of the person concerned. A phenomenological approach was selected to investigate this phenomenon. Heidegger's hermeneutic phenomenology is used as a frame of reference. The study is exploratory, descriptive first level research. Its method incorporates the use of: dialogue as interviews with patients who have been recently diagnosed as having colorectal cancer over a time-span of twelve months; field notes; diary analysis; additional sources of information such as drawings, poetry and photographs and Colaizzi's method of transcript analysis (Haase, 1987).

For the purpose of this study, in order to describe and come to understand the Dasein of colorectal cancer, unstructured interviews which are conducted in a dialogical way were selected (Parse, 1998).

The study is being conducted in three hospitals in Switzerland. Since the beginning of the data collection in March 1999 seven subjects were found. They all agreed to talk about their experience of having recently been diagnosed with colorectal cancer. In the discussions with

the subjects it became clear that, as opposed to general beliefs, loss is not as much an issue as locus of control. Wherever the person believes his or her locus of control is situated, i.e. external or internal, he or she acts accordingly. It appears that persons with an external locus of control consider themselves to be victims of their situation, whereas persons with an internal locus of control consider themselves to be in charge.

Temporarily the conclusion may be drawn that the fast turnover of patients in acute care hospitals asks for a focus on individual care. Health care professionals should concentrate on conducing more in-depth discussions with the patients.

1. Introduction

Cancer and its manifestations have been widely discussed in the medical, oncology and nursing literature. Many studies were focused on coping strategies used to deal with cancer (Klauer and Filipp, 1997). The aim was to develop more accurate models of coping and strategies of intervention (Klauer and Filipp, 1997). Particular attention has been paid to breast cancer in terms of psychological issues (Margulies et al., 1994). However, intestinal cancer is considered to be one of the most frequent causes for mortality of all cancers (Späti and Fust, 1997, Norum, 1998). In fact the number of intestinal cancer is increasing (Semmens et al., 2000). Over the last two decades extensive literature has been devoted to breaking bad news to patients and their families, as well as how to conduct informative talks with cancer patients (Brewin, 1977; Buckman, 1984; Schwarzer, 1990; Sahay et al., 2000). Many areas for improvement have been suggested on how better to break bad news to the patients. Burton (1991) for example advocates tuning into the patients' mood and reflecting it back to them; whereas Sahay et al. (2000) conclude that information to cancer patients should be provided in everyday language for better understanding. According to my own experience patients in surgical care only have their interventions and leave shortly afterwards. Neither the nurses nor the doctors learn about the time after the hospital discharge and the subsequent treatment. Hence, the research question presented itself: what is the experience of being told about having colorectal cancer and the meaning of this cancer for the future life of the person concerned? To investigate the experience, a phenomenological approach was selected. Heidegger's Hermeneutic Phenomenology was used as a frame of reference. The study is exploratory, descriptive first level research. Its method incorporates the use of:

- Dialogue (as interviews) with patients who have recently been diagnosed with having colorectal cancer over a time-span of twelve months
- Field notes
- Diary analysis
- Colaizzi's method of transcript analysis (Haase, 1987).

The names used for the subjects are fictional and bear no relation to the subjects themselves.

2. Methodology

2.1. Engaging in a Dialogic

In order to describe and come to understand the Dasein of colorectal cancer, unstructured interviews conducted in a dialogical way were selected to describe and come to understand the Dasein of colorectal cancer, (Burns and Grove, 1993; Gray, 1994; Rose, 1994; Sorrell and Redmond, 1995; Parse 1998). Engaging in a dialogic, or dialogue, is considered to be the best way to come to understand a phenomenon. By engaging in a dialogic, the researcher is expected to *be with* the subject in 'true presence' (Parse, 1998: 64-65). 'True presence' means the researcher is centred on the subject and the content of the dialogue. The researcher follows the lead of the participant and joins in the flow of the dialogue. Hence, silences are viewed as important. Prompting the subject is only considered valid in the form of reflecting on a previous train of thought or gently to use a forward urging phrase (Parse, 1998: 64-65) to advance the discussion. The dialogic invites the subject to describe his or her Being-in-the-world. The subject decides about the pace of answering, and where the answers lead to. The process is reciprocal and applies to both researcher and subject. Both convey their Dasein as Being-in-the-world. They bring their own history, their world, Being-in and entity, into the dialogic. Both are with each other, and together they create a world in which the Being-in-the-world can be revealed and described in speech. Hence, both shape the situation, which in turn shapes them (Sorrell and Redmond, 1995; Parse, 1996). Therefore, the Heideggerian view that a person is as much shaped by his or her environment as the environment is shaped by the person, is true for the dialogic situation (Heidegger, 1993; Koch, 1995; Heidegger, 1996). Engaging in a dialogic about a phenomenon may have a positive or even 'healing' effect for the researcher and subject (Sorrell and Redmond, 1995: 1120; Parse, 1998).

2.2. The Field Notes

Field notes are made to record important issues surrounding a dialogue, a meeting with a subject or an important event. All field notes are narratives in the research. Almost all first encounters with the subjects have been recorded in field notes as a tape recorder did not seem appropriate. A tape recorder would introduce an artificial element to the initial encounter.

2.3. The Diary

To record personal issues and events and to monitor the changes in myself, I kept a diary. The diary will now be used to shed light on the encounters with the subjects and to illuminate my reflections on the research.

2.4. The Analysis

To expose data from the research, analysis needs to be conducted. As Heideggerian Hermeneutic Phenomenology was selected, it would be appropriate to use the Hermeneutic circle. However, throughout Heidegger's work, the description and application of the Hermeneutic Circle remains vague. Colaizzi (Haase, 1987), however, listed several steps to analyse phenomenological research data. These are based on Heidegger's Hermeneutic Phenomenology and thus are appropriate for use in the present research.

2.5. Ethical Issues

The initial meetings and all telephone contacts were recorded as field notes; if possible verbatim. Issues concerning the environment of a meeting and some discussions with health care professionals were also recorded as field notes. The dialogics were subsequently tape-recorded with a recording machine. They were transcribed verbatim to facilitate analysis (Sandelowski, 1993).

For confirmation of substance the final results of the analysis were returned to the subjects. By engaging the subjects in a review of the analysis, the accuracy of the data could be determined. This is considered important to achieve credibility of the data. An expert panel also reviewed and commented on the analysis. Using the expertise of a panel in reviewing the data is also considered to enhance the credibility of the findings.

3. The Procedure

From early March 1999 until late May 1999 I was given access to approach patients in three different hospitals in Zurich, Schlieren and Aarau (three towns in Switzerland). During that time I met fifteen patients, diagnosed with colorectal cancer, seven of whom consented to participate in the research. Much to my surprise six out of the seven patients decided on the spot to participate. One subject was unsure about his future and felt reluctant to agree to participation in the study. The subject did not like the idea of having interviews tape-recorded. In fact, all of our dialogues occurred via the telephone. However, as our relationship grew, the subject asked me to ring him again and again.

3.1. My Being-in-the-world

In the first months of data collection, I experienced changes in moods. At my first meeting with Mr Walters, I felt enthusiastic and was convinced of the need for my study. Mr Walters agreed to take part immediately. I experienced this as a boost to my motivation. I had hoped that the mood of elation would persist, but debates with medical personnel undermined my mood. In the subsequent meetings with potential subjects, I felt more hesitant. The next five patients were not interested in participating in my research. The general tenor was that they did not mind talking to me right then about what had happened to them, but they would not wish to continue the discussions after they had gone home. Why would the patients not want to participate in a study following hospital care, I asked myself? Based on the statements with which the patients answered my approach, I concluded that they wished to 'close the book' after they left the hospital. After reviewing my approach to the patients, I was more successful in attracting subjects to the research.

When I returned to bedside practice, the most profound changes in me became apparent. I had developed my skills in approaching patients and was able to respond to them fairly quickly. That resulted in many positive encounters with patients and rewarding in-depth discussions with most of them. It was a rather new and overwhelming experience for me to find myself so attuned to patient needs and problems.

4. Tentative Results

Having not yet analysed all data, only a tentative approach to the findings can be presented here.

4.1. The Themes: Illness/Procedure, Family and Colostomy

All the data can be structured into the themes: Illness and Procedure; Family and Colostomy. Within the theme 'illness and procedure' the descriptions and developments relating to the tumour are summarised. Usually the subjects described the first symptoms, the subsequent discovery of the tumour and their reaction to it. Much emphasis was laid on to the operation and subsequent treatment, including radiotherapy and chemotherapy. This included statements about complications either related to the operation or the subsequent treatments. Quite often expressions of hope accompanied the descriptions of the illness. Mrs Baker, for example, hopes that "the illness is more or less OK. The doctor was able to take most of the tumour away. But now one has to wait for the test results."

The theme 'family' encompasses all statements pertaining to the family of the participant, how they provided support throughout the discovery and treatment of the illness. When Mr Horvath had to be hospitalised again, his wife came to see him daily. He was glad about her visits: "That is wonderful." Usually, they would go for a short walk in the hospital's garden. Some subjects also had a close and trusting relationship with doctors. Hence, such statements were attributed to this group, as well as descriptions of the subjects' everyday life. Statements pertaining to the study were also attributed to that group, as the subjects and I developed rather close bonds over the 6 to 12 months of the data collection. Even now, I am still in contact with all of the subjects as they are validating their analysed data.

The category 'colostomy' is limited as there were only four of the seven subjects, who were confronted with a colostomy. Three subjects confronted with a replaceable colostomy had difficulties in accepting it. Mrs Monod stated: "The colostomy is the very worst. It is so dirty!" In the beginning, she was unable to look at the colostomy without nausea. In contrast Mr Oliver, who was confronted with a colostomy for life, seemed to accept it fairly easily. He learned to handle it very quickly and took an interest in informing other people about his positive regard for the colostomy. In the three cases where the colostomy was temporary, the subjects touched upon its replacement. The category 'colostomy' was an issue for discussion and provided insight into the reaction of the subejcts to being confronted with a colostomy.

4.2. Locus of Control, Understanding and Moods

Within these three themes, locus of control and the Heideggerian concepts of understanding and moods seem to be pertinent issues. Locus of control can either be internal or external with corresponding effects for the person. Having an internal locus of control allows a person to be more in charge of the situation, to act and to make decisions. In contrast, a person with an external locus of control reacts or waits for some decision by somebody else. Connors et al. (1994) explain that it is normal to oscillate between external and internal locus of control. However, one should attempt to move towards an internal locus of control. Mrs Baker was the first to use actually the words 'independence' and 'dependence'. On our second contact she explained that "before the illness she had been independent. She had made her own decisions. Now she felt extremely dependent." In contrast to the experience of dependence by Mrs Baker, Mr Oliver described himself as a very positive and inquisitive person. Indeed, he asked a lot of questions of me and the medical personnel when unsure of a situation or curious to know more. However, in the final dialogic he said that there was a genuine limit to gathering information. He did not wish to know all there is to know about his illness. I felt Mr Oliver's attitude was similar to that of Mrs Monod. At first, the locus of control was not very important for her. However, she had decided not to undergo further chemotherapy as she was not tolerating it well. Now, her colostomy has been replaced and she feels much better than before. However, the clear-cut pictures about locus of control are not to be found in other subjects. Some of them may seem to have an external locus of control and react more than act in certain situations (Hallis and Slone, 1999). They may then change and have an internal locus of control in other situations. Mr Horvath at first appeared to be very much a victim of his illness. In order to relieve the colon of the tumour-induced irritations, he received a colostomy. Subsequently he had to undergo chemotherapy and radiotherapy before the actual operation to remove the tumour could occur. However, in terms of an internal locus of control, during the therapeutic treatments Mr Horvath felt in control and went on a holiday to his beloved home land, Hungary.

In the attribution of internal or external locus of control, the Heideggerian concepts of understanding and moods seem to play an important role. Mr Horvath decided suddenly to go home to Hungary and was rewarded with a great holiday. That experience helped him to decide to travel to Hungary again. This second trip was overshadowed by a physical crisis. He said: "I almost died." Despite that, and the knowledge that the crisis could also have happened here in Switzerland Mr Horvath had confidence in travelling again.

The mood of Mr Horvath also influenced his thoughts about the illness. There were days when he felt well. Then the thoughts of his illness were less present. "I just don't want to think about it!" But on other days, his thoughts are turning in a circle which is not helpful at all.

Mr Oliver on the other hand surprised the medical personnel with his jokes and easy mood. "But I don't know how to be different. This is my way of being. Otherwise I couldn't stand it."

Mrs Monod decided to stop the chemotherapy, as she did not feel well at all. However, she gathered information beforehand and thus understood the magnitude of her decision. She was completely aware that cessation of chemotherapy might result in a greater probability of the cancer returning. Nevertheless, Mrs Monod was prepared to accept this probability in order to have a better quality of life and to feel better in general.

5. Conclusion

Heidegger's Hermeneutic Phenomenology (1993; 1996) aids in understanding the experience of being told about having colorectal cancer and its meaning for the future life of the person concerned. It might be useful to instruct healthcare professionals in some of Heidegger's views. Also, 'true presence' might become a concept to teach health care professionals in how to deal with potentially problematic situations. My transcripts and subsequent analysis points to a clear need for more in-depth discussions in the hospital with nurses. As far as I can see, nursing care should concentrate on inducing a dialogue between carers and patients. Only then can a therapeutic relationship, as proposed by many nurse theorists and educationalists, become possible. In the increasing challenge of ever-shortening hospital stays, individual care with in-depth discussions should be high on the agenda for carers.

References

Brewin, T., B., (1977) "The cancer patient: communication and morale." *British Medical Journal*, 24-31 December 1977, (6103): 1623-1627.

Burns, N., and Grove, S., K., (1993) *The practice of nursing research.* Conduct, critique and utilization (2nd Edition). Philadelphia: W. B. Saunders.

Buckman, R., (1984) "Breaking bad news: why is it still so difficult?" *British Medical Journal*, 288 (6430): 1597-1599.

Burton, M., V., (1991) "Counselling in routine care: a client-centred approach." (pp. 74-93) In: Watson, M., (ed.), (1991) *Cancer patient care: psychosocial treatment methods*. Cambridge: Cambridge University Press and BPS Books.

Connors, R., Smith, T., and Hickman, C., (1994) *The Oz principle. Getting results through individual and organizational accountability*. Paramus, NJ: Prentice Hall.

Gray, M., (1994) "Personal experience of conduction unstructured interviews." *Nurse Researcher*, 1 (3): 65-71.

Haase, J., E., (1987) "Components of courage in chronically ill adolescents: a phenomenological study." *Advances in Nursing Science*, 9 (2): 64-80.

Hallis, D., and Slone, M., (1999) "Coping strategies and locus of control as mediating variables in relation between exposure to political life events and psychological adjustment in Israeli children." *International Journal of Stress Management*, 6 (2): 105-123.

Heidegger, M., (1993) *Sein und Zeit*. (17. Auflage). Tübingen: Max Niemeyer.

Heidegger, M., (1996) *Being and Time*. Translated by John Macquarrie and Edward Robinson. Reprinted. Oxford: Blackwell.

Klauer, T., and Filipp, S.-H., (1997) "Formen der Krankheitsbewältigung bei Krebspatienten." (pp. 377-404) In: Schwarzer, R., (ed.), (1997) *Gesundheitspsychologie. Ein Lehrbuch*. 2. überarbeitete und erweiterte Auflage. Bern: Hogrefe.

Koch, T., (1995) „Establishing rigour in qualitative research: the decision trail." *Journal of Advanced Nursing*, 19: 976-986.

Margulies, A., Fellinger, K., Kroner, T., and Gaisser, A., (Hrsg.), (1994) *Onkologische Krankenpflege*. Berlin: Springer.

Norum, J., (1998) "Quality of life in colorectal cancer patients treated with doxorubicin and a multi-drug resistance (MDR) modulator (SDZ PSC-833): a pilot study." *Anticancer Research*, July, 18 (4C): 2933-2936.

Parse, R., R., (1996) "The human becoming theory: challenges in practice and research." *Nursing Science Quarterly*, 9 (2): 55-60.

Parse, R., R., (1998) *The human becoming school of thought. A perspective for nurses and other health professionals*. (Reviewed edition of Man-Living-Health). London: Sage.

Rose, K., (1994) "Interviewing techniques. Unstructured and semi-structured interviewing." *Nurse Researcher*, 1 (3): 23-32.

Sahay, T., B., Gray., R., E., and Fitch, M., (2000) "A qualitative study of patient perspective on colorectal cancer." *Cancer Practice*, January, 8 (1): 38-44.

Sandelowski, M., (1993) "Theory unmasked: the uses and guises of theory in qualitative research." *Research in Nursing & Health*, 16: 213-218.

Schwarzer, R., (ed.), (1990) *Gesundheitspsychologie. Ein Lehrbuch*. Göttingen: Hogrefe. Verlag für Psychologie.

Semmens, J., B., Platell, C., Threlfall, T., J., and Holman, C., D., J., (2000) "A Population-based study of the incidence, mortality and outcomes in patients following surgery for colorectal cancer in Western Australia." *Australian and New Zealand Journal of Surgery*, January, 70 (1): 11-18.

Sorrell, J., M., and Redmond, G., M., (1995) "Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies." *Journal of Advanced Nursing*, 21 (6): 1117-1122.

Späti, B., and Fust, R., (1997) "Gastrointestinal Tumours." (pp. 360-377) In: Glaus, A., Jungi, W., F., and Senn, H.-J., (eds.) *Onkologie für Pflegeberufe*. 5. überarbeitete Auflage. Stuttgart: Thieme.

Publication 2

A paper presented at the University of Halle/Wittenberg in a workshop of the Institute of Nursing about ‚scientific concepts in oncology nursing', 7-8 December 2000 in Wittenberg/Germany.

Title:

Das Dasein mit Kolorektalkrebs. Eine ontologische Studie.

Autorin:

Frau Maya Shaha
Schwirrenmattweg 12 C
5034 Suhr
Schweiz

Betreuerin:

Frau Dr. Carol Cox
City University - St Bartholomew School of Nursing and Midwifery
London EC1A 7QN

1. Einführung

In der medizinischen, onkologischen und Pflegeliteratur sind Krebs und dessen Manifestationen oft und eingehend diskutiert worden. Hauptsächlich befassten sich die Studien mit Bewältigungsstrategien im Zusammenhang mit Krebs (Klauer und Filipp, 1997). Man beabsichtigte genauere Modelle zur Bewältigung, sowie Interventionsstrategien zu entwickeln (Klauer und Filipp, 1997). Psychologische Aspekte bei Brustkrebs wurden besonders intensiv bearbeitet (Margulies et al., 1994). Krebs im Intestinalbereich gilt jedoch als eine der häufigsten Todesursachen von allen Krebsarten (Späti und Fust, 1997; Norum, 1998). Tatsächlich ist die Zahl von Intestinalkrebs steigend (Semmens et al., 2000). In den vergangenen drei Jahrzehnten widmete sich ein Grossteil der Literatur der Kommunikation zwischen medizinischem Personal und Krebspatientinnen und Patienten. Von speziellem Interesse waren das Mitteilen von negativen Nachrichten an Patientinnen und Patienten, sowie an Angehörige, als auch die Ausübung und Durchführung von Informationsgesprächen mit Krebspatientinnen und -patienten (Brewin, 1977; Buckman, 1984; Schwarzer, 1990; Sahay et al., 2000). Um besser negative Nachrichten den Patientinnen und Patienten mitzuteilen, wurden verschiedene Vorschläge aufgezeigt. Burton (1991) schlägt beispielweise vor, dass man sich in die Stimmung der Patientinnen und Patienten einzufühlen, und diese zu wiederspiegeln versucht. Dagegen kommen Sahay et al. (2000) zum Schluss, dass jegliche Information an Krebspatientinnen und -patienten in der Alltagssprache weitergegeben werden muss. Aus eigener Erfahrung weiss ich, dass Patientinnen und Patienten das Spital kurz nach einem chirurgischen Eingriff verlassen. Weder die Pflegenden, noch die Ärzte erfahren etwas über die Zeit zu Hause und die anschliessenden Behandlungen. Das führte mich zu folgender Forschungsfrage: Wie erlebt man die Mitteilung, dass man Kolorektalkrebs hat und welche Auswirkungen hat dieser Krebs auf das weitere Leben der betroffenen Person? Ein phänomenologischer Ansatz schien am Geeignetsten, um diese Erfahrung zu untersuchen. Ich entschied mich für Heidegger's hermeneutische Phänomenologie als Referenzrahmen. Die Studie ist eine exploratorische Forschung. Die folgenden Methoden wurden angewandt:

- Dialoge (als Interviews) über eine Zeitspanne von 13 Monaten mit Patientinnen und Patienten, die kürzlich die Diagnose Kolorektalkrebs erhalten haben.

- Feldnotizen
- Tagebuchanalyse
- Colaizzi's Methode der Datenanalyse (Haase, 1987)

Die verwendeten Namen sind frei erfunden und haben keinen Bezug zu den Subjekten selber.

2. Methodologie

2.1. Einen Dialog führen

Um das Dasein mit Kolorektalkrebs zu beschreiben und es zu verstehen, wurden unstrukturierte Interviews ausgewählt, die in einer Dialogform durchgeführt wurden (Burns und Grove, 1993; Gray, 1994; Rose, 1994; Sorrell und Redmond, 1995; Parse, 1998). Einen Dialog führen wird als der beste Weg beschrieben, um ein Phänomen kennen zu lernen und es zu verstehen. In einem Dialog wird vom Forscher[357] erwartet, dass er dem Subjekt offen und wahrhaftig gegenüber tritt (being in true presence; Parse, 1998: 64-65). ‚Being in true presence' bedeutet für den Forscher, dass er sich auf das Subjekt und den Inhalt des Dialoges konzentriert. Der Forscher folgt der Führung des Subjektes und geht mit dem Fluss des Dialoges. Daher werden Pausen als wichtig erachtet. Erlaubt sind Reflexionen über einen Gedankengang oder sanfte Aufforderungen, um einen Dialog wieder vorwärts zu orientieren (Parse, 1998: 64-65). Der Dialog lädt das Subjekt ein, sein In-der-Welt-sein zu beschreiben. Das Subjekt entscheidet wie rasch die Antwort erfolgen soll, und wohin die Antworten führen. Der Prozess ist reziprok und gilt sowohl für das Subjekt wie auch den Forscher. Beide stellen ihr Dasein als In-der-Welt-sein dar. Sie bringen ihre eigene Geschichte, ihre Welt, ihr In-Sein und ihr Seiendes in den Dialog hinein. Beide sind miteinander und zusammen schaffen sie eine Welt, worin das In-der-Welt-sein enthüllt und mit Hilfe der Sprache beschrieben werden kann. Also formen beide die Situation, die wiederum beide beeinflusst (Sorrell und Redmond, 1995; Parse, 1996). Somit ist die Heidegger'sche Ansicht, dass eine Person ebenso sehr durch ihr Umfeld geformt wird, wie das Umfeld die Person formt, auch zutreffend für die Dialogsituation (Heidegger, 1993; Koch, 1995; Heidegger, 1996). Über ein Phänomen einen Dialog führen kann auf den Forscher und auf das Subjekt einen positiven oder sogar einen ‚heilenden' Effekt haben (Sorrell und Redmond, 1995: 1120; Parse, 1998). In meiner Studie hat sich das bestätigt.

2.2. Die Feldnotizen

In den Feldnotizen wurden wichtige Aspekte bezüglich eines Dialogs, eines Kontaktes mit einem Subjekt oder andere wichtige Begebenheiten festgehalten. Alle Feldnotizen dieser Forschung sind Narrative.

2.3. Das Tagebuch

Um persönliche Anliegen und Begebenheiten festzuhalten, und um die Veränderungen in mir selber zu verfolgen, führte ich während der Studie ein Tagebuch. Es wird nun dazu dienen, meine Begegnungen mit den Subjekten und meine Überlegungen zur Forschung zu illustrieren.

2.4. Die Analyse

Um wichtige Daten aus der Forschung herauszuheben ist ein analytischer Prozess notwendig. Da Heidegger's hermeneutische Phänomenologie gewählt wurde, wäre die Verwendung der Hermeneutik vielleicht angepasster. Doch Heidegger selber bleibt in der Beschreibung und Anwendung der Hermeneutik vage. Colaizzi (Haase, 1987) hat mehrere Schritte aufgelistet, um phänomenologische Forschungsdaten zu analysieren. Daher schien eine Analyse nach Colaizzi am Geeignetsten.

- Durch das Transkribieren der Daten erhält man eine Idee der zentralen Aussagen in den Daten.
- Herausschälen der signifikanten Aussagen.

---

[357] Obwohl die männliche Bezeichnung benutzt wird, is die weibliche Bezeichnung immer miteingeschlossen.

- Abstrahieren der signifikanten Aussagen.
- Formulierung einer Hauptaussage und Validierung derselben durch Expertinnen und/oder Experten.
- Gruppierung der Hauptaussagen in Themen, Themengruppen und Themenkategorien.
- Integrierung der Themen in eine erschöpfende, ausführliche Beschreibung des zu untersuchenden Phänomens.
- Formulierung einer Aussage über die essentielle Struktur.
- Validierung der essentiellen Struktur durch die Studienteilnehmerinnen und Studienteilnehmer (Haase, 1987: 66-67).

2.5. Ethische Überlegungen

Die ersten Begegnungen und alle telefonischen Kontakte wurden als Feldnotizen aufgezeichnet; wenn möglich wortwörtlich. Auch Aspekte bezogen auf die Umstände einer Begegnung und einige Diskussionen mit Ärzteschaft und Pflegenden wurden als Feldnotizen festgehalten. Die Dialoge wurden mit einem Kassettenrekorder aufgenommen und anschliessend wörtlich transkribiert, um die Analyse zu vereinfachen (Sandelowski, 1993).

Die Endresultate der Analyse werden zur Bestätigung der Substanz den Subjekten zur Überprüfung vorgelegt. Indem man die Subjekte in den Analyseprozess mit einbezieht, kann die Genauigkeit der Daten festgestellt werden. Zudem überprüft ein Expertinnenpanel die Analyse der Daten. Diese Schritte werden in Bezug auf die Glaubhaftigkeit der Daten als wichtig erachtet.

3. Das Vorgehen

Von März bis Mai 1999 wurde mir erlaubt, Patientinnen und Patienten in drei chirurgischen Abteilungen verschiedener Spitäler - in Zürich, Schlieren und Aarau - anzufragen. Während dieser Zeit begegnete ich 15 Patienten, die gerade eben mit der Diagnose Kolorektalkrebs konfrontiert worden waren. Sieben Patienten entschlossen sich, an der Studie teilzunehmen. Zu meiner grossen Überraschung entschlossen sich sechs der sieben Patienten auf Anhieb bei der Studie mitzumachen. Ein Subjekt war unsicher in Bezug auf seine Zukunft und zögerte mit der Zustimmung zur Studie. Auch war ihm die Vorstellung, dass die Gespräche auf Kassettenrekorder aufgezeichnet werden, unangenehm. Tatsächlich fanden alle unsere Dialoge über Telefon statt. Im Laufe der Zeit, forderte mich das Subjekt immer wieder auf, mich telefonisch zu melden.

3.1. Mein In-der-Welt-sein

In den ersten Monaten der Datensammlung erlebte ich Stimmungsänderungen. In meiner ersten Begegnung mit Herrn Walter war ich enthusiastisch und überzeugt von der Notwendigkeit meiner Studie. Herr Walter hat sofort zugesagt, an der Studie teilzunehmen. Das war ein Motivationsschub. Ich hatte gehofft, dass diese gute Stimmung vorhalten würde, doch denke ich, dass Debatten mit der Ärzteschaft meine Stimmung untergraben haben. In den folgenden Begegnungen mit potentiellen Subjekten war ich zurückhaltender. Tatsächlich waren die nächsten fünf Patienten nicht an einer Teilnahme interessiert. Grundsätzlich wären jene fünf Patienten nicht abgeneigt gewesen, mit mir im Moment über ihre Erlebnisse und Erfahrungen zu sprechen. Doch wünschten sie nicht, dass die Gespräche nach ihrer Rückkehr nach Hause fortgeführt würden. Daher begann ich mich zu fragen: warum die Patienten sich nicht an einer Studie beteiligen wollten, die über die Spitalaufenthaltsdauer hinausführte? Ich schloss aus den Antworten der Patienten, dass sie nach Ende des Spitalaufenthalts das ‚Buch zu schliessen' wünschen. Nach Überprüfung meiner Art auf die Patienten zuzugehen, hatte ich mehr Erfolg im Finden von Subjekten für die Studie.

Als ich für kurze Zeit im Herbst 1999 in die Pflegepraxis zurückkehrte, bemerkte ich grundlegende Veränderungen in mir. Ich hatte meine Fähigkeit, auf Patienten zuzugehen weiter entwickelt und konnte nun rascher einen Kontakt herstellen. Daraus resultierten einige positive Begegnungen mit Patienten, sowie reiche intensive Gespräche mit den meisten. Es war eine eher neue und etwas überwältigende Erfahrung, mich so auf die Bedürfnisse und Probleme von Patienten eingestimmt zu finden.

4. Vorläufige Resultate

Momentan bin ich damit beschäftigt die Analyse zu ihrem Ende zu führen. Hier präsentiere ich einen Zwischenschritt in der Analyse der Daten, der hauptsächlich eine Kondensierung der Daten ist.

4.1. Die Themen: Krankheit/Prozedere, Familie und Stoma

In einem ersten Analyseschritt wurden die Daten die Themen: Krankheit/Prozedere, Familie und Stoma strukturiert. Im Thema ‚Krankheit/Prozedere' waren die Beschreibungen und Entwicklungen in Bezug auf den Tumor zusammengefasst. Üblicherweise begannen die Subjekte mit der Beschreibung der ersten Symptome, der anschliessenden Entdeckung des Tumors und ihrer Reaktion darauf. Besonders die Operation und die darauffolgenden Behandlungen, inklusive Chemotherapie und Radiotherapie, wurden eingehend erläutert. Beschreibungen von Komplikationen, entweder von der Operation resultierend oder den nachfolgenden Behandlungen, wurden ebenfalls dieser Gruppe zugeführt. Häufig fanden sich Aussagen von Hoffnung zusammen mit den Beschreibungen der Krankheit. Frau Bucher hoffte, beispielsweise, dass „die Krankheit nun mehr oder weniger in Ordnung ist. Der Arzt hat das Meiste davon entfernen können. Nun muss man aber auf die Resultate warten."

Das Thema Familie beinhaltete alle Aussagen über die Familie der Subjekte und deren Unterstützung in der ganzen Zeit der Entdeckung und der Behandlung der Krankheit. Als Herr Horvath nochmals hospitalisiert werden musste, besuchte ihn seine Ehefrau täglich. Er war sehr froh über ihre Besuche: „Das ist wunderbar." Meistens unternahmen sie einen kurzen Spaziergang in den Spitalpark. Einige Subjekte hatten auch eine enge und vertrauensvolle Beziehung zur Ärzteschaft. Daher wurden auch solche Aussagen in dieser Gruppe miteinbezogen, sowie Beschreibungen des Alltags der Subjekte. Aussagen zur Studie wurden ebenfalls dieser Gruppe zugeordnet, da die Subjekte und ich über die 6 bis 12 Monate der Datensammlung enge Bindungen entwickelten. Auch jetzt noch bin ich mit allen Subjekten in Kontakt, da sie noch die Analyse der Daten validieren.

Nicht in allen Daten der Subjekte liessen sich Aussagen zum Thema ‚Stoma' finden. Nur vier der sieben Subjekte waren mit einer Ileostomie oder Kolostomie konfrontiert. Drei Subjekte, mit reversiblen Stomata, hatten ihre Schwierigkeiten damit. Frau Monod sagte: „Das Stoma ist das Allerschlimmste. Es ist so schmutzig!" Zu Beginn war es ihr kaum möglich, das Stoma ohne Nausea anzusehen. Ganz im Gegensatz dazu schien Herr Ott, der mit einem irreversiblen Stoma konfrontiert war, es einfach zu akzeptieren. Er lernte sehr schnell, mit dem Stoma umzugehen und interessierte sich dafür, anderen Betroffenen seine positiven Ansichten über das Stoma weiterzugeben. Die drei Subjekte mit den reversiblen Stoma sprachen auch oft über die Rückverlegung. Das Thema ‚Stoma' war heiss diskutiert und stellt eindrücklich die Reaktionen der Subjekte dar, die mit einem Stoma konfrontiert worden sind.

4.2. Sitz der Kontrollverstärkung, Verstehen und Befindlichkeit

Als zweiter Analyseschritt folgte die Abstraktion der jeweiligen Aussagen der Subjekte. In einem weiteren Schritt wurden die Abstraktionen der einzelnen Subjekte untereinander verglichen und Ähnliche gruppiert. Nun traten zentrale Themen hervor. Besonders der Sitz der Kontrollverstärkung, und Heidegger's Konzepte Verstehen und Befindlichkeit schienen eine grosse Rolle zu spielen. Der Sitz der Kontrollverstärkung kann sowohl innerlich wie äusserlich sein mit entsprechenden Auswirkungen für die betroffene Person. Hat man einen innerlichen Sitz der Kontrollverstärkung, scheint man die Situation im Griff zu haben, man agiert und fällt Entscheidungen. Dagegen scheint eine Person mit einem äusserlichen Sitz der Kontrollverstärkung eher zu reagieren, oder zu warten, bis jemand anders eine Entscheidung getroffen hat. Klare Aussagen in Bezug auf den Sitz der Kontrollverstärkung sind aber kaum auffindbar. Connors et al., (1994) erklären, dass es normal ist, zwischen äusserlichem und innerlichem Sitz der Kontrollverstärkung zu oszillieren. Man sollte jedoch versuchen, einen innerlichen Sitz der Kontrollverstärkung anzustreben. Frau Bucher brauchte als erste die Begriffe ‚Unabhängigkeit' und ‚Abhängigkeit'. In unserer zweiten Begegnung erklärte sie, dass sie „vor der Krankheit unabhängig war. Sie hatte ihre eigenen Entscheidungen getroffen. Nun fühlte sie sich extrem abhängig." Im Gegensatz zu der Erfahrung der Abhängigkeit von Frau Bucher, beschrieb sich Herr Ott als sehr positiver und neugieriger Mensch. Tatsächlich stellte er viele Fragen an mich und an das medizinische Personal, wenn er über etwas im Unklaren war oder mehr wissen wollte. Im abschliessenden Gespräch sagt er jedoch, dass der Wunsch nach Informationen begrenzt ist. Er wolle nicht alles über seine Krankheit wissen. Herr Ott's Haltung schien mir ähnlich der von Frau Monod. Zuerst war der Sitz der Kontrollverstärkung nicht wichtig für sie. Jedoch entschied sie sich gegen eine Fortführung der Chemotherapie, da sie schwere Reaktionen darauf hatte. Nachdem das Stoma zurückverlegt worden war, fühlte sie sich viel besser als zuvor. Klar-umrissene Bilder vom Sitz des Kontrollverstärkers waren eher selten bei den anderen Subjekten. Einige schienen einen äusserlichen Sitz des Kontrollverstärkers zu haben und reagierten mehr, als dass sie agierten in entsprechenden Situationen (Hallis und Slone, 1999). Andererseits zeigten sie auch einen innerlichen Sitz des Kontrollverstärkers. Herr Horvath schien anfänglich ein Opfer der Krankheit zu sein. Um das Kolon von den tumorinduzierten Irritationen zu befreien, musste ihm ein Entlastungsstoma angelegt werden. Anschliessend unterzog er sich Chemotherapien und Radiotherapien vor der eigentlichen operativen Tumorentfernung. In Bezug auf innerlichen Sitz des Kontrollverstärkers ist zu erwähnen, dass Herr Horvath die Situation während der therapeutischen Behandlungen so sehr im Griff hatte, dass er in sein Heimatland Ungarn in die Ferien fuhr.

Im Zusammenhang mit dem Sitz des Kontrollverstärkers scheinen die Heidegger'schen Konzepte Verstehen und Befindlichkeit eine wichtige Rolle zu spielen. Herr Horvath entschied sich plötzlich für die Ferienreise und hatte eine tolle Zeit. Diese Erfahrung half ihm, sich noch einmal für eine Reise nach Ungarn zu entscheiden. Dieser zweite Aufenthalt war von einer physischen Krise überschattet. Er sagte: „Ich wäre fast gestorben." Trotzdem und dank des Wissens, dass diese Krise ebenso gut in der Schweiz hätte geschehen können, hat Herr Horvath die Zuversicht, erneut zu reisen.

Bei beiden, Herrn Horvath und Herrn Ott, beeinflusste die Befindlichkeit die Gedanken über die Krankheit. Herr Ott überraschte das medizinische Personal mit seinen Scherzen und Aufgelegtheit. „Aber ich kann nicht anders. So bin ich nun mal. Ich könnte es sonst nicht aushalten."

Frau Monod entschied sich für einen Abbruch der Chemotherapie, da sie sich überhaupt nicht wohl fühlte. Doch sie sammelte zuvor Informationen und war sich daher der Tragweite ihrer Entscheidung bewusst. Sie war sich im Klaren, dass der Abbruch der Chemotherapie die Möglichkeit eines Rückfalls des Krebses erhöhte. Dennoch, Frau Monod war bereit, diese Möglichkeit zu akzeptieren, um eine bessere Lebensqualität zu erhalten und sich besser zu fühlen.

5. Vorläufige Schlussfolgerungen

Heidegger's (1993; 1996) hermeneutische Phänomenologie unterstützt das Verstehen wie eine Person die Diagnose Kolorektalkrebs und deren Auswirkungen auf das weitere Leben erfährt. Für medizinisches Personal könnten Einführungen in einige Konzepte von Heidegger hilfreich sein, besonders im Bezug auf Empathie und Verständnis gegenüber der SItuation. ‚Being in true presence' könnte medizinisches Personal in potentiell schwierigen Situationen unterstützen. Die Daten der Studie und deren Analyse deuten klar auf eine erhöhte Notwendigkeit für intensive Gespräche zwischen medizinischem Personal und Patienten. Soweit ich sehen kann, sollte sich die Pflege darauf konzentrieren, einen Dialog zwischen Patienten und den Betreuenden zu erwirken. Nur dann kann die therapeutische Beziehung, wie sie von vielen Pflegetheoretikerinnen und -akademikerinnen propagiert wird, möglich werden. In der immer grösser werdenden Herausforderung von immer kürzer werdenden Spitalaufenthalten, sollte individuelle Pflege mit intensiven Gesprächen zuoberst auf der Agenda der Pflege stehen.

Referenzen

Brewin, T., B., (1977) "The cancer patient: communication and morale." *British Medical Journal*, 24-31 December 1977, (6103): 1623-1627.

Burns, N., und Grove, S., K., (1993) *The practice of nursing research. Conduct, critique and utilization.* 2nd edn. Philadelphia: W. B. Saunders.

Buckman, R., (1984) "Breaking bad news: why is it still so difficult?" *British Medical Journal*, 288 (6430): 1597-1599.

Burton, M., V., (1991) "Counselling in routine care: a client-centred approach." (pp. 74-93) In: Watson, M., (ed.) *Cancer patient care: psychosocial treatment methods.* Cambridge: Cambridge University Press and BPS Books.

Connors, R., Smith, T., und Hickman, C., (1994) *The Oz principle.* Getting results through individual and organizational accountability. Paramus, NJ: Prentice Hall.

Gray, M., (1994) "Personal experience of conduction unstructured interviews." *Nurse Researcher,* 1 (3): 65-71.

Haase, J., E., (1987) "Components of courage in chronically ill adolescents: a phenomenological study." *Advances in Nursing Science,* 9 (2): 64-80.

Hallis, D., and Slone, M., (1999) "Coping strategies and locus of control as mediating variables in relation between exposure to political life events and psychological adjustment in Israeli children." *International Journal of Stress Management,* 6 (2): 105-123.

Heidegger, M., (1993) *Sein und Zeit.* (17. Auflage). Tübingen: Max Niemeyer.

Heidegger, M., (1996) *Being and Time.* Translated by John Macquarrie and Edward Robinson. Reprinted. Oxford: Blackwell.

Klauer, T., und Filipp, S.-H., (1997) "Formen der Krankheitsbewältigung bei Krebspatienten." (pp. 377-404) In: Schwarzer, R., (ed.), (1997) *Gesundheitspsychologie. Ein Lehrbuch.* 2. überarbeitete und erweiterte Auflage. Bern: Hogrefe.

Koch, T., (1995) „Establishing rigour in qualitative research: the decision trail." *Journal of Advanced Nursing,* 19: 976-986.

Margulies, A., Fellinger, K., Kroner, T., und Gaisser, A., (eds.), (1994) *Onkologische Krankenpflege.* Berlin: Springer.

Norum, J., (1998) "Quality of life in colorectal cancer patients treated with doxorubicin and a multi-drug resistance (MDR) modulator (SDZ PSC-833): a pilot study." *Anticancer Research,* July, 18 (4C): 2933-2936.

Parse, R., Rizzo, (1996) "The human becoming theory: challenges in practice and research." *Nursing Science Quarterly,* 9 (2): 55-60.

Parse, R., Rizzo, (1998) *The human becoming school of thought. A perspective for nurses and other health professionals.* (Reviewed edition of Man-Living-Health). London: Sage.

Rose, K., (1994) "Interviewing techniques. Unstructured and semi-structured interviewing." *Nurse Researcher,* 1 (3): 23-32.

Sahay, T., B., Gray., R., E., und Fitch, M., (2000) "A qualitative study of patient perspective on colorectal cancer." *Cancer Practice,* January, 8 (1): 38-44.

Sandelowski, M., (1993) "Theory unmasked: the uses and guises of theory in qualitative research." *Research in Nursing & Health,* 16: 213-218.

Schwarzer, R., (ed.), (1990) *Gesundheitspsychologie. Ein Lehrbuch.* Göttingen: Hogrefe. Verlag für Psychologie.

Semmens, J., B., Platell, C., Threlfall, T., J., und Holman, C., D., J., (2000) "A Population-based study of the incidence, mortality and outcomes in patients following surgery for colorectal cancer in Western Australia." *Australian and New Zealand Journal of Surgery,* January, 70 (1): 11-18.

Sorrell, J., M., und Redmond, G., M., (1995) "Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies." *Journal of Advanced Nursing,* 21 (6): 1117-1122.

Späti, B., und Fust, R., (1997) "Gastrointestinal Tumours." (pp 360-377) In: Glaus, A., Jungi, W., F., und Senn, H.-J., (eds.) *Onkologie für Pflegeberufe.* 5. überarbeitete Auflage. Stuttgart: Thieme.

Publication 3

A paper presented at the 5th International Seminar for Oncology Nursing - Advanced Practice. European School for Oncology. University of St Gall (HSG). 9000 St Gall/Switzerland, 23-24 August 2001.

Title:

Das Dasein mit Kolorektalkrebs. Eine ontologische Studie.

Autorin:

Frau Maya Shaha

Schwirrenmattweg 12 C

5034 Suhr

Schweiz

Betreuerin:

Frau Dr. Carol Cox

City University - St Bartholomew School of Nursing and Midwifery

London EC1A 7QN

Abstrakt:

Die Studie *Das Dasein mit Kolorektalkrebs* beabsichtigte, die gelebte Erfahrung darzustellen, wenn einer Person mitgeteilt wird, dass sie an Kolorektalkrebs leidet und die Bedeutung dessen für das weitere Leben der betroffenen Person. Zur Erforschung dieses Phänomens wurde ein phänomenologischer Ansatz, sowie Heideggers Phänomenologie als Referenzrahmen gewählt[1]. Die Studie war exploratorisch. Dialoge als Interviews über eine Zeitspanne von 12 Monaten mit Patienten, die erst vor kurzem erfahren haben, dass sie an Kolorektalkrebs leiden, wurden angewendet. Unstrukturierte Interviews, als Dialog geführt, wurden als sehr geeignet gefunden, um das Dasein mit Kolorektalkrebs zu beschreiben und zu verstehen[2]. Des Weiteren wurden Feldnotizen; Tagebuch-Analyse und Colaizzi's Datenanalysemethode[3] verwendet.

In den chirurgischen Abteilungen von drei Schweizer Spitälern, unterschiedlicher Grösse, konnten insgesamt sieben Patienten als Studienteilnehmende gewonnen werden. Alle waren einverstanden, ihre Erfahrung, erst kürzlich mit Kolorektalkrebs diagnostiziert worden zu sein, darzustellen. In den Gesprächen stellte sich heraus, dass - ganz im Gegensatz zu den üblichen Vorstellungen - Verlust nicht unbedingt das zentrale Thema ist. Vielmehr sind Angst, Furcht, sowie der Sitz der Kontrollverstärkung bedeutsam. Angst und Furcht scheinen besonders anfänglich, nach Erhalt der Diagnose und dem Einsetzen der Therapien, bestimmend zu sein. Aber sie verschwinden, auch nach Abschluss der Therapien, nie vollständig. Unabhängig davon, wo der Sitz der Kontrollverstärkung sich befindet - innen oder aussen - reagiert man auf die Situation. Befindet sich der Sitz der Kontrolle aussen, scheint es, dass man sich eher als Opfer einer Situation fühlt. Umgekehrt scheint ein innerer Sitz der Kontrollverstärkung zu bedeuten, dass man die Situation im Griff hat. Ob der Sitz der Kontrollverstärkung sich aussen oder innen befindet, scheint - unter anderem - mit den Heidegger'schen Existentialen Verstehen und Befindlichkeit zusammenzuhängen.

Im Erleben einer Diagnose von Kolorektalkrebs scheinen Angst, Furcht und der Sitz der Kontrollverstärkung bestimmende Rollen einzunehmen. Um die Zusammenhänge besser zu verstehen, hat sich Heidegger's Phänomenologie als erhellend erwiesen. Als vorläufiger Schluss kann festgehalten werden, dass der hohe Umsatz an Patienten in den Akutspitälern eine klare Ausrichtung auf die individuelle Pflege verlangt. Berufleute des

Gesundheitswesens sollten sich darauf konzentrieren, tiefgehende und intensive Gespräche mit den Patienten zu initiieren.

[1] Heidegger, M., (1993) *Sein und Zeit.* (17. Auflage). Tübingen: Max Niemeyer.

Heidegger, M., (1996) *Being and Time.* Translated by J. Macquarrie and E. Robinson. Reprinted. Oxford: Blackwell.

[2] Parse, R., R., (1998) *The human becoming school of thought. A perspective for nurses and other health professionals.* London: Sage.

Sorrell, J., M., and Redmond, G., M., (1995) "Interviews in qualitative nursing research: differing approaches of ethnographic and phenomenological studies." *Journal of Advanced Nursing,* 21 (6): 1117-1122.

[3] Haase, J., E., (1987) "Components of courage in chronically ill adolescents: A phenomenological study." *Advances in Nursing Science,* 9 (2): 64-80.

1. Einführung

Sehr geehrte Anwesende

Ich bin Krankenschwester IKP und Doktorandin der Pflegewissenschaften an der City University in London, Grossbritannien. Zur Erlangung der Doktorwürde in Pflegewissenschaften an selbiger Universität ist es notwendig, eine Forschungsarbeit durchzuführen. Nach der Diplomierung zur Krankenschwester war ich vor allem in chirurgischen Abteilungen tätig. Dabei hatte ich einige Mal die Gelegenheit, Patienten mit Kolorektalkrebs zu betreuen. Im Laufe der Zeit erkannte ich, wie wenig über die Nachbehandlung und Nachbetreuung dieser Patienten bekannt war. Dies wirkte sich entsprechend auf die Pflege aus. Mein Interesse an dieser Patientengruppe wurde so stark, dass ich mich entschloss, sie zum Thema der Doktorarbeit zu machen.

2. Problembeschreibung

Krebs und dessen Manifestationen sind in der Literatur oft und eingehend diskutiert worden. Studien befassten sich hauptsächlich mit Bewältigungsstrategien im Umgang mit Krebs, mit dem Ziel, genauere Modelle zur Bewältigung, sowie Interventionsstrategien zu entwickeln (Klauer und Filipp, 1997). Aber auch die psychologischen Aspekte, besonders bei Brustkrebs, wurden intensiv bearbeitet (Margulies et al., 1994). Tatsächlich gilt Krebs im Intestinalbereich zunehmend als eine der häufigsten Todesursachen von allen Krebsarten (Späti und Fust, 1997; Norum, 1998; Semmens et al., 2000).

In den vergangenen drei Jahrzehnten widmete sich ein Grossteil der Literatur der Kommunikation zwischen medizinischem Personal und Krebspatientinnen und -patienten. Von speziellem Interesse war das Mitteilen von negativen Nachrichten an Patienten, sowie an Angehörige. Ebenso standen die Ausübung und Durchführung von Informationsgesprächen mit Krebspatienten im Mittelpunkt (Brewin, 1977; Buckman, 1984; Schwarzer, 1990; Sahay et al., 2000). Um Patienten besser negative Nachrichten mitzuteilen, wurden verschiedene Vorschläge aufgezeigt. Burton (1991) beispielweise schlug vor, dass man sich in die Stimmung der Patienten einzufühlen, und diese zu wiederspiegeln versucht. Dagegen kamen Sahay et al. (2000) zum Schluss, dass jegliche Information an Krebspatienten in der Alltagssprache weitergegeben werden muss. Aus eigener Erfahrung weiss ich, dass Patienten das Spital kurz nach einem chirurgischen Eingriff verlassen. Weder die Pflegenden, noch die Ärzte erfahren etwas über die Zeit zu Hause und die anschliessenden Behandlungen. Das führte mich zu folgender Forschungsfrage: Wie erlebt man die Mitteilung, dass man Kolorektalkrebs hat und welche Auswirkungen hat dieser Krebs auf das weitere Leben der betroffenen Person?

Ein phänomenologischer Ansatz schien am Geeignetsten, um diese Erfahrung zu untersuchen. Ich entschied mich für Heidegger's Phänomenologie (1993; 1996) als Referenzrahmen. Die Studie ist eine exploratorische Forschung. Die folgenden Methoden wurden angewandt:

- Dialoge (als Interviews) über eine Zeitspanne von 12 Monaten mit Patientinnen und Patienten, die kürzlich (maximal 6 Monate) die Diagnose Kolorektalkrebs erhalten haben.

- Feldnotizen
- Tagebuchanalyse
- Colaizzi's Methode der Datenanalyse (Haase, 1987)

Die verwendeten Namen sind frei erfunden und haben keinen Bezug zu den Patienten selber.

3. Methodologie

Anschliessend werde ich einige Aspekte der Methodologie vorstellen. Dazu gehören eine Begründung für den theoretischen Bezugrahmen, sowie einen kurzen Abriss über die Datensammlungsinstrumente. Es wird auch eine kleine Einführung in die Analysemethode gegeben.

3.1. Der theoretische Bezugrahmen

In der Pflegeliteratur werden die Einflüsse der beiden deutschen Philosophen Husserl und Heidegger oft und detailliert beschrieben (Koch, 1995; Mills, 1994; Oiler, 1981; Omery, 1983). Die philosophischen Ansichten sowohl von Husserl, als auch von Heidegger stellen nach Ansicht der Pflegewissenschafterinnen und Pflegewissenschafter eine ideale Grundlage für die Bestrebungen der Pflege, sich der Ganzheitlichkeit zu widmen (Hallett, 1994; Plager, 1994). Heidegger's Bestreben, die Frage nach dem Sein zu beantworten, führte zu detaillierten Beschreibungen und einer Analyse des alltäglichen Seins der Menschen. Dabei wird besonders das Zukunftsweisende, die Möglichkeiten des Seins und die Bedeutung der Stimmung hervorgehoben. Heidegger's Philosophie schien daher die beste Grundlage für die Studie über das Erleben von Patientinnen und Patienten mit Kolorektalkrebs zu sein.

3.2. Einen Dialog führen

Um das Dasein mit Kolorektalkrebs zu beschreiben und es zu verstehen, wurden unstrukturierte Interviews ausgewählt, die in einer Dialogform durchgeführt wurden (Burns und Grove, 1993; Gray, 1994; Rose, 1994; Sorrell und Redmond, 1995; Parse, 1998). Einen Dialog führen wird als der beste Weg beschrieben, um ein Phänomen kennen zu lernen und es zu verstehen. In einem Dialog wird vom Forscher erwartet, dass er dem Subjekt offen und wahrhaftig gegenüber tritt (being in true presence; Parse, 1998: 64-65). ‚Being in true presence' bedeutet für den Forscher, dass er sich auf das Subjekt und den Inhalt des Dialoges konzentriert. Der Forscher folgt der Führung des Subjektes und geht mit dem Fluss des Dialoges. Daher werden Pausen als wichtig erachtet. Erlaubt sind Reflexionen über einen Gedankengang oder sanfte Aufforderungen, um einen Dialog wieder vorwärts zu orientieren (Parse, 1998: 64-65). Der Dialog lädt das Subjekt ein, sein In-der-Welt-sein zu beschreiben. Das Subjekt entscheidet wie rasch die Antwort erfolgen soll, und wohin die Antworten führen. Der Prozess ist reziprok und gilt sowohl für das Subjekt wie auch den Forscher. Beide stellen ihr Dasein sich als In-der-Welt-sein dar. Sie bringen ihre eigene Geschichte, ihre Welt, ihr In-Sein und ihr Seiendes in den Dialog hinein. Beide sind miteinander und zusammen schaffen sie eine Welt, worin das In-der-Welt-sein enthüllt und mit Hilfe der Sprache beschrieben werden kann. Also formen beide die Situation, die wiederum beide beeinflusst (Sorrell und Redmond, 1995; Parse, 1996). Somit ist die Heidegger'sche Ansicht, dass eine Person ebenso sehr durch ihr Umfeld geformt wird, wie das Umfeld die Person formt, auch zutreffend für die Dialogsituation (Heidegger, 1993; Koch, 1995; Heidegger, 1996).

In der Studie erwiesen sich einfache Intervieweinladungen wie „Wie geht es Ihnen?" als idealer Schlüssel. Die Patienten ergriffen die Einladung gerne und erzählten meist bereits während des ersten Treffens von ihren Erlebnissen zu ihrer Erkrankung.

Über ein Phänomen einen Dialog führen kann auf den Forscher und auf das Subjekt einen positiven oder sogar einen ‚heilenden' Effekt haben (Sorrell und Redmond, 1995: 1120; Parse, 1998). In meiner Studie hat sich das bestätigt.

3.3. Andere Datensammlungsinstrumente

Neben Interviews in Dialogform wurden noch Feldnotizen geführt. Darin wurden wichtige Aspekte bezüglich eines Dialogs, eines Kontaktes mit den Patienten oder andere wichtige Begebenheiten festgehalten. Alle Feldnotizen dieser Forschung waren Narrative und flossen in die Interviews ein.

Um persönliche Anliegen und Begebenheiten festzuhalten, und um die Veränderungen in mir selber zu verfolgen, führte ich während der Studie ein Tagebuch. Sowohl die Feldnotizen, als auch die Tagebuchtexte dienten in der Analyse dazu, die Begegnungen mit den Patienten und meine Überlegungen zur Forschung zu illustrieren.

Die Sichtung des Tagebuchs hat ergeben, dass sich die anfänglichen Schwierigkeiten, einen Zugang zu den Patienten zu finden, mich stark beeinflussten.

3.4. Die Analyse

Da ein qualitativer Forschungsansatz gewählt wurde, sollte die Analysemethode dem gerecht werden. Mit der Wahl von Heidegger's Phänomenologie als Bezugrahmen, wäre die Verwendung des hermeneutischen Zirkels vielleicht angepasster. In *Sein und Zeit*, Heidegger's (1993; 1996) Hauptwerk, das als philosophische Basis diente, wird der hermeneutische Zirkel jedoch nur oberflächlich beschrieben. Die Anwendung und der Zugang zu den Daten bleiben etwas vage. Im qualitativen Paradigma wurden verschiedene Ansätze zur Analyse von phänomenologischer Forschung erarbeitet. Colaizzi (Haase, 1987) entwickelte mehrere Schritte zur Analyse phänomenologischer Forschungsdaten. Die auf den ersten Blick detailliert und klar erscheinenden Schritte schienen geeignet zur Analyse der Daten in der Studie, die sich mit dem Erleben von Kolorektalkrebspatienten befasste.

- Durch das Transkribieren der Daten erhält man eine Idee der zentralen Aussagen in den Daten.
- Herausschälen der signifikanten Aussagen.
- Abstrahieren der signifikanten Aussagen.
- Formulierung einer Hauptaussage und Validierung derselben durch Expertinnen und/oder Experten.
- Gruppierung der Hauptaussagen in Themen, Themengruppen und Themenkategorien.
- Integrierung der Themen in eine erschöpfende, ausführliche Beschreibung des zu untersuchenden Phänomens.
- Formulierung einer Aussagen über die essentielle Struktur.
- Validierung der essentiellen Struktur durch die Studienteilnehmerinnen und Studienteilnehmer (Haase, 1987: 66-67).

Um die Schritte von Colaizzi überhaupt anwenden zu können, musste ich zuerst die Fülle von Daten - sie füllten einen Bundesordner - kondensieren. Die verschiedenen Interviews und Feldnotizen wurden in etwa fünf Teilschritten zusammengefasst. Dadurch traten die wichtigsten Aussagen hervor. Erst jetzt war es möglich, die Aussagen zu umformulieren und weiter zu abstrahieren. Daraus entstanden verschiedene Kategorien, aus denen heraus zwei Konzepte und ein übergreifendes Hauptthema identifiziert werden konnten. Dieser Prozess dauerte insgesamt ein Jahr. Hinderlich dabei war die detailgetreue Art der Erzählung. Es war schwierig, sich von den täglichen Fakten der Patientinnen und Patienten zu lösen, beispielsweise die Mühen der Chemotherapie.

3.5. Ethische Überlegungen

Die ersten Begegnungen und alle telefonischen Kontakte wurden als Feldnotizen aufgezeichnet; wenn möglich wortwörtlich. Auch Aspekte bezogen auf die Umstände einer Begegnung und einige Diskussionen mit Ärzteschaft und Pflegenden wurden als Feldnotizen festgehalten. Die weiterführenden Dialoge wurden mit einem Kassettenrekorder aufgenommen und anschliessend wörtlich transkribiert, um die Analyse zu vereinfachen (Sandelowski, 1993).

Um die Glaubhaftigkeit der Daten zu untermauern, wurden die Teilschritte und die Endresultate der Analyse zur Bestätigung der Substanz den Patienten zur Überprüfung vorgelegt. Ein Expertinnenpanel überprüfte zusätzlich sowohl die Analyse der Daten als auch die Endresultate.

4. Das Vorgehen

Von März bis Mai 1999 wurde mir erlaubt, Patienten in drei chirurgischen Abteilungen verschiedener Spitäler - in Zürich, Schlieren und Aarau - anzufragen. Während dieser Zeit begegnete ich 15 Patienten, die gerade eben mit der Diagnose Kolorektalkrebs konfrontiert worden waren. Sieben Patienten entschlossen sich, an der Studie teilzunehmen. Zu meiner grossen Überraschung entschlossen sich sechs der sieben Patienten auf Anhieb bei der Studie mitzumachen. Ein Patient war unsicher in Bezug auf seine Zukunft und zögerte mit der Zustimmung zur Studie. Auch war ihm die Vorstellung, dass die Gespräche auf Kassettenrekorder aufgezeichnet werden, unangenehm. Tatsächlich fand ein Grossteil unserer Dialoge am Telefon statt. Aber der Patient forderte mich immer wieder auf, mich telefonisch zu melden. Mit den anderen sechs Patienten fand eine unterschiedliche Anzahl von Dialogen statt. Zusätzlich dazu sprachen wir in regelmässigen Abständen am Telefon.

5. Vorläufige Resultate

Im Moment bin ich mit dem Aufschreiben der Arbeit beschäftigt. Die Analyse ist abgeschlossen. Es konnten zwei grosse Themen herausgearbeitet werden, sowie ein alles umfassendes Konzept. Sehr zentral sind darin Angst und Neu-Orientierung. Im Folgenden werde ich die Kondensierung der Daten illustrieren. Darin enthalten sind Unterthemen, die in die zwei Hauptthemen eingeflossen sind.

5.1. Krankheit/Prozedere, Familie und Stoma

In einem ersten Kondensationsschritt wurden die Daten in die Kategorien: Krankheit/Prozedere, Familie und Stoma strukturiert. In der Kategorie ‚Krankheit/Prozedere' waren die Beschreibungen und Entwicklungen in Bezug auf den Tumor zusammengefasst. Üblicherweise begannen die Patienten mit der Beschreibung der ersten Symptome, der anschliessenden Entdeckung des Tumors und ihrer Reaktion darauf. Besonders die Operation und die darauffolgenden Behandlungen, inklusive Chemotherapie und Radiotherapie, wurden eingehend erläutert. Einige der Patienten waren zusätzlich mit Komplikationen, entweder von der Operation resultierend oder den nachfolgenden Behandlungen, konfrontiert. Zusammen mit den Beschreibungen der Krankheit fanden sich auch häufig Aussagen von Hoffnung. Frau Bucher hoffte, beispielsweise, dass „die Krankheit nun mehr oder weniger in Ordnung ist. Der Arzt hat das Meiste davon entfernen können. Nun muss man aber auf die Resultate warten."

In der Kategorie Familie wurden Aussagen über die Familie der Patientinnen und Patienten und deren Unterstützung in der ganzen Zeit der Entdeckung und der Behandlung der Krankheit subsummiert. Als Herr Horvath nochmals hospitalisiert werden musste, besuchte ihn seine Ehefrau täglich. Er war sehr froh über ihre Besuche: „Das ist wunderbar." Meistens unternahmen sie einen kurzen Spaziergang in den Spitalpark. Einige Patienten hatten auch eine enge und vertrauensvolle Beziehung zur Ärzteschaft. Die Beschreibung des Alltags und Aussagen zur Studie wurden dieser Kategorie auch zugeordnet. Über die 6 bis 12 Monate der Datensammlung entwickelten die Patienten und ich enge Bindungen. Noch immer pflege ich den Kontakt zu allen Patienten, da bis zum vollständigen Abschluss der Arbeit noch die Validierung der Datenanalyse durch die Patienten durchgeführt werden muss.

Aussagen zum Thema ‚Stoma' liessen sich in den Texten von fünf Patienten finden. Darunter waren vier Patienten mit einer Ileostomie oder Kolostomie konfrontiert. Drei Patienten, mit reversiblen Stomata, hatten ihre Schwierigkeiten damit. Frau Monod sagte: „Das Stoma ist das Allerschlimmste. Es ist so schmutzig!" Zu Beginn war es ihr kaum möglich, das Stoma ohne Nausea anzusehen. Ganz im Gegensatz dazu schien Herr Ott, der mit einem irreversiblen Stoma konfrontiert war, es einfach zu akzeptieren. Er lernte sehr schnell, mit dem Stoma umzugehen und interessierte sich dafür, anderen Betroffenen seine positiven Ansichten über das Stoma weiterzugeben. Die drei Patienten mit den reversiblen Stoma sprachen auch oft über die Rückverlegung. Das Thema ‚Stoma' war heiss diskutiert und stellt eindrücklich die Reaktionen der Subjekte dar, die mit einem Stoma konfrontiert worden sind.

In allen diesen Kategorien kamen die Angst und die Furcht im Umgang mit der Krankheit stark zum Tragen. Oft sprachen die Patienten ihre Furcht aus, konnten sie aber nicht begründen. Die Krankheit nahm einen grossen Teil im Alltag und Erleben der Patienten ein. Kaum ein Tag verging, an dem sie nicht an ihre Krankheit erinnert wurden. Besonders im

Zusammenhang mit dem Stoma fühlten sich die Patienten stark mit der Bedrohlichkeit der Krankheit konfrontiert. Im Zusammenhang mit dem Stoma wurde denn auch die Angst konkret. Man fürchtete sich beispielsweise vor Infektionen. Die Mobilität wurde als eingeschränkt erachtet, da man sich davor fürchtete, der Stomabeutel könnte abfallen.

5.2. Sitz der Kontrollverstärkung, Verstehen und Befindlichkeit

Zwei weitere Kondensationsschritte bewirkten stärkere Abstraktion der jeweiligen Aussagen der Patienten. Die Abstraktionen der einzelnen Patientinnen und Patienten wurden anschliessend untereinander verglichen und Ähnliche gruppiert. Hier schienen sich nun zum ersten Mal die vermuteten zentralen Themen erahnen. Neben den Ängsten und der Furcht, schienen nun besonders der Sitz der Kontrollverstärkung, und Heidegger's Existentiale Verstehen und Befindlichkeit eine grosse Rolle zu spielen.

Dass der Sitz der Kontrollverstärkung in diesem Zusammenhang zum Tragen kommt, ist einigermassen erstaunlich. In der Psychologie konnten bis jetzt keine klaren Zusammenhänge zwischen dem Sitz der Kontrollverstärkung und den Bewältigungsmechanismen im Falle von Krankheiten dargestellt werden (Schwarzer, 1990). Der Sitz der Kontrollverstärkung spielt vielmehr in der ökonomischen Literatur eine grosse Rolle. Er kann sowohl innerlich wie äusserlich sein mit entsprechenden Auswirkungen für die betroffene Person. Hat man einen innerlichen Sitz der Kontrollverstärkung, scheint man die Situation im Griff zu haben, man agiert und fällt Entscheidungen. Dagegen scheint eine Person mit einem äusserlichen Sitz der Kontrollverstärkung eher zu reagieren, oder zu warten, bis jemand anders eine Entscheidung getroffen hat. Klare Aussagen in Bezug auf den Sitz der Kontrollverstärkung sind aber kaum auffindbar. Connors et al. (1994) erklären, dass es normal ist, zwischen äusserlichem und innerlichem Sitz der Kontrollverstärkung zu oszillieren. Man sollte jedoch versuchen, einen innerlichen Sitz der Kontrollverstärkung anzustreben. Keine der 7 Patienten hat diesen Begriff der Kontrollverstärkung gebraucht. Aber die Begriffe ‚Unabhängigkeit' und ‚Abhängigkeit' nahmen wichtige Positionen in den Gesprächen ein. Frau Bucher brauchte als erste die beiden Begriffe. In unserer zweiten Begegnung erklärte sie, dass sie „vor der Krankheit unabhängig war. Sie hatte ihre eigenen Entscheidungen getroffen. Nun fühlte sie sich extrem abhängig." Auch die anderen Patienten erlebten die Diagnose der Krankheit ähnlich. Plötzlich schienen andere Kräfte Einfluss in ihrem Leben zu nehmen. Die scheinbar durch die Krankheit induzierte Abhängigkeit wurde von Herrn Ott nicht so stark empfunden. Er beschrieb sich als sehr positiver und neugieriger Mensch. Tatsächlich stellte er viele Fragen an mich und an das medizinische Personal, wenn er über etwas im Unklaren war oder mehr wissen wollte. Im abschliessenden Gespräch sagt er jedoch, dass der Wunsch nach Informationen begrenzt ist. Er wolle nicht alles über seine Krankheit wissen. Also, setzt auch die eigene Haltung dem Sitz der Kontrollverstärkung Grenzen. ‚Unabhängigkeit' wurde nicht in jedem Fall als erstrebenswert gesehen. Interessant ist in diesem Zusammenhang die Haltung von Frau Monod. Durch die Krankheit sah sie sich an viele Termine gebunden, schien sich aber nicht darüber zu stören. Erst als Komplikationen in der Chemotherapie sie stark reduzierten in ihrem Allgemeinzustand, entschied sie sich gegen eine Fortführung. Nachdem das Stoma zurückverlegt worden war, fühlte sie sich viel besser als zuvor. Klar-umrissene Bilder vom Sitz des Kontrollverstärkers waren eher selten. Einige Subjekte schienen einen äusserlichen Sitz des Kontrollverstärkers zu haben und reagierten mehr, als dass sie agierten in entsprechenden Situationen (Hallis und Slone, 1999). Andererseits zeigten sie auch einen innerlichen Sitz des Kontrollverstärkers. Herr Horvath schien anfänglich ein Opfer der Krankheit zu sein. Um das Kolon von den tumorinduzierten Irritationen zu befreien, musste ihm ein Entlastungsstoma angelegt werden. Anschliessend unterzog er sich Chemotherapien und Radiotherapien vor der eigentlichen operativen Tumorentfernung. Dennoch hatte Herr Horvath die Situation während der therapeutischen Behandlungen so sehr im Griff, dass er in die Ferien fuhr.

Im Zusammenhang mit dem Sitz des Kontrollverstärkers schienen die Heidegger'schen Existentiale Verstehen und Befindlichkeit eine wichtige Rolle zu spielen. Mit Befindlichkeit deutete Heidegger (1993; 1996) auf die enge Verknüpfung von Erleben und Laune hin. Der Ausdruck ‚Verstehen' beinhaltet gemäss Heidegger (1993; 1996) mehr als das blosse Begreifen. ‚Verstehen' hat vielmehr einen Zusammenhang mit dem Ausblick in die Zukunft und der Bedeutung des Vergangenen für Gegenwart und Zukunft. Herr Horvath, beispielsweise, entschied sich plötzlich für die Ferienreise und hatte eine tolle Zeit. Diese Erfahrung half ihm, sich noch einmal für eine Reise zu entscheiden. Dieser zweite Aufenthalt war von einer physischen Krise überschattet. Er sagte: „Ich wäre fast gestorben." Trotzdem und dank des Wissens, dass diese Krise ebenso gut in der Schweiz hätte geschehen können, hat Herr Horvath die Zuversicht, erneut zu reisen. Befindlichkeit beeinflusste auch die Gedanken über die Krankheit. Herr Ott überraschte das medizinische Personal mit seinen Scherzen und Aufgelegtheit. „Aber ich kann nicht anders. So bin ich nun mal. Ich könnte es sonst nicht aushalten." Nochmals zurück zu Frau Monod. Sie entschied sich für einen Abbruch der Chemotherapie, da sie sich überhaupt nicht wohl fühlte. Doch sie sammelte zuvor Informationen und war sich daher der Tragweite ihrer Entscheidung bewusst. Sie war sich im Klaren, dass der Abbruch der Chemotherapie die Möglichkeit eines Rückfalls des Krebses erhöhte. Dennoch, Frau Monod war bereit, diese Möglichkeit zu akzeptieren, um eine bessere Lebensqualität zu erhalten und sich besser zu fühlen.

5.3. Hauptthemen

Nachdem mehrere Kondensationsschritte durchgeführt worden waren, konnten bedeutsame Aussagen besser herausgefiltert werden. Im Durchgehen der ‚Kondensate' trat klar zu Tage, dass Konzepte wie Angst, Furcht und der Sitz der Kontrollverstärkung, sowie Bewältigungsstrategien zentrale Rollen im Erleben der Patienten mit einer Kolorektalkrebsdiagnose spielen. Interessant ist darunter das Konzept des Sitzes der Kontrollverstärkung. Die Psychologie hat sich eingehend mit diesem Konzept befasst und konnte keine eindeutigen Korrelationen feststellen. Doch die Darstellungen der Studienteilnehmenden weisen auf die Bedeutsamkeit des Sitzes der Kontrollverstärkung hin. Weiterführende Forschung wäre notwendig, um allfällige Interferenzen und Korrelationen festzustellen.

6. Vorläufige Schlussfolgerungen

Heidegger's Phänomenologie (1993; 1996) unterstützt das Verstehen, wie eine Person die Diagnose Kolorektalkrebs und deren Auswirkungen auf das weitere Leben erfährt. Für medizinisches Personal könnten Einführungen in Teile von Heidegger's Phänomenologie hilfreich sein, besonders im Bezug auf Empathie und Verständnis gegenüber der Situation der Patienten. ‚Being in true presence' könnte medizinisches Personal in potentiell schwierigen Situationen unterstützen. Die Daten der Studie und deren Analyse deuten klar auf eine erhöhte Notwendigkeit für intensive Gespräche zwischen medizinischem Personal und Patienten. Soweit ich sehen kann, sollte sich die Pflege darauf konzentrieren, einen Dialog zwischen Patienten und den Betreuenden zu erwirken. Nur dann kann die therapeutische Beziehung, wie sie von vielen Pflegetheoretikerinnen und -akademikerinnen propagiert wird, möglich werden. In der immer grösser werdenden Herausforderung von immer kürzer werdenden Spitalaufenthalten, sollte individuelle Pflege mit intensiven Gesprächen zuoberst auf der Agenda der Pflege stehen.

Referenzen

Brewin, T., B., (1977) "The cancer patient: communication and morale." *British Medical Journal*, (6103): 1623-1627 (24-31 December 1977).

Burns, N., und Grove, S., K., (1993) *The practice of nursing research. Conduct, critique and utilization*. 2nd ed. Philadelphia: W. B. Saunders.

Buckman, R., (1984) "Breaking bad news: why is it still so difficult?" *British Medical Journal*, 288 (6430): 1597-1599.

Burton, M., V., (1991) "Counselling in routine care: a client-centred approach." (pp. 74-93) In: Watson, M., (ed.), (1991) *Cancer patient care: psychosocial treatment methods*. Cambridge: Cambridge University Press and BPS Books.

Connors, R., Smith, T., und Hickman, C., (1994) *The Oz principle*. Getting results through individual and organizational accountability. Paramus, NJ: Prentice Hall.

Gray, M., (1994) "Personal experience of conduction unstructured interviews." *Nurse Researcher*, 1 (3): 65-71.

Haase, J., E., (1987) "Components of courage in chronically ill adolescents: a phenomenological study." *Advances in Nursing Science*, 9 (2): 64-80.

Hallett, C., (1995) "Phenomenology. Understanding the phenomenological approach to research." *Nurse Researcher*, 3 (2): 55-65.

Hallis, D., and Slone, M., (1999) "Coping strategies and locus of control as mediating variables in relation between exposure to political life events and psychological adjustment in Israeli children." *International Journal of Stress Management*, 6 (2): 105-123.

Heidegger, M., (1993) *Sein und Zeit*. (17. Auflage). Tübingen: Max Niemeyer.

Heidegger, M., (1996) *Being and Time*. Translated by John Macquarrie and Edward Robinson. Reprinted. Oxford: Blackwell.

Klauer, T., und Filipp, S.-H., (1997) "Formen der Krankheitsbewältigung bei Krebspatienten." (pp. 377-404) In: Schwarzer, R., (ed.), (1997) *Gesundheitspsychologie. Ein Lehrbuch*. 2. überarbeitete und erweiterte Auflage. Bern: Hogrefe.

Koch, T., (1995) "Establishing rigour in qualitative research: the decision trail." *Journal of Advanced Nursing*, 19: 976-986.

Margulies, A., Fellinger, K., Kroner, T., und Gaisser, A., (eds.), (1994) *Onkologische Krankenpflege*. Berlin: Springer.

Mills, C., (1994) "Research Methods: Phenomenology." *Surgical Nurse*, 7 (2): 27-29.

Norum, J., (1998) "Quality of life in colorectal cancer patients treated with doxorubicin and a multi-drug resistance (MDR) modulator (SDZ PSC-833): a pilot study." *Anticancer Research*, July, 18 (4C): 2933-2936.

Oiler, C., (1981) "The phenomenological approach in nursing research." *Nursing Research*, 31 (3): 178-181.

Omery, A., (1983) "Phenomenology: a method for nursing research." *Advances in Nursing Science*, 5: 49-63.

Parse, R., Rizzo, (1996) "The human becoming theory: challenges in practice and research." *Nursing Science Quarterly*, 9 (2): 55-60.

Parse, R., Rizzo, (1998) *The human becoming school of thought. A perspective for nurses and other health professionals*. (Reviewed edition of Man-Living-Health). London: Sage.

Rose, K., (1994) "Interviewing techniques. Unstructured and semi-structured interviewing." *Nurse Researcher*, 1 (3): 23-32.

Sahay, T., B., Gray., R., E., und Fitch, M., (2000) "A qualitative study of patient perspective on colorectal cancer." *Cancer Practice*, January, 8 (1): 38-44.

Sandelowski, M., (1993) "Theory unmasked: the uses and guises of theory in qualitative research." *Research in Nursing & Health*, 16: 213-218.

Schwarzer, R., (ed.), (1990) *Gesundheitspsychologie*. Ein Lehrbuch. Göttingen: Hogrefe. Verlag für Psychologie.

Semmens, J., B., Platell, C., Threlfall, T., J., und Holman, C., D., J., (2000) "A Population-based study of the incidence, mortality and outcomes in patients following surgery for colorectal cancer in Western Australia." *Australian and New Zealand Journal of Surgery*, January, 70 (1): 11-18.

Sorrell, J., M., und Redmond, G., M., (1995) "Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies." *Journal of Advanced Nursing*, 21 (6): 1117-1122.

Späti, B., und Fust, R., (1997) "Gastrointestinal Tumours." (pp. 360-377) In: Glaus, A., Jungi, W., F., und Senn, H.-J., (eds.) *Onkologie für Pflegeberufe*. 5. überarbeitete Auflage. Stuttgart: Thieme.

Publication 4

Presentation at the European Honour Society Inaugural Conference of Nurses and Midwives. Enhancing the Practice Experience. March 8, 2002. Published in: Cox, C., (ed.), (2002) *Enhancing the practice experience. A collection of papers. European Honour Society 2002.* Bournemouth: Nursing Praxis International.

Title: **The Omnipresence of Cancer**

Study in fulfilment of the PhD in Nursing Science at City University - St Bartholomew School of Nursing and Midwifery, 20 Bartholomew Close, London EC1A 7QN.

Author

Maya Shaha
Schwirrenmattweg 12 C
CH-5034 Suhr

Internal Supervisor

Dr Carol Lynn Cox
City University - St Bartholomew School of Nursing and Midwifery
Bartholomew Close
London EC1A 7QN

External Supervisor

Dr Silvia Käppeli
UniversitätsSpital Zürich
Sonneggstrasse 6
CH-8091 Zürich

Abstract

The project described in this paper was undertaken in partial fulfilment of a PhD in Nursing Degree at City University, London (UK). The study undertaken addressed the phenomena of living with the diagnosis of colorectal cancer. The incidence of intestinal cancer like colorectal cancer has increased over the past few decades. Reasons for the trend were tentatively attributed to nutrition and ways of life, but also to hereditary reasons. A need was identified to describe the lived experience of having received a diagnosis of colorectal cancer and what this means for the individual concerned. To explore the lived experience of colorectal cancer a phenomenological study was developed based on Heidegger's philosophy as presented in his seminal work 'Being and Time' (1993; 1996). Seven patients diagnosed with colorectal cancer were interviewed over a time-span of twelve months. The patients were recruited from three Swiss hospitals.

Analysis following Colaizzi's eight steps as cited in Haase (1987: 66-67) exposed the core theme 'the omnipresence of cancer' and two sub-themes that were called 'towards authen-

tic Dasein' and 'mapping out the future'. Underlying the first sub-theme are Fear[358] (Heidegger, 1993: 140ff; 1996: 179ff) and Anxiety (Heidegger, 1993: 184ff; 1996: 228ff), whereas the second sub-theme is based on the Existential Understanding (Heidegger, 1993: 142ff; 1996: 182ff) and on hope. It was demonstrated that having received a diagnosis of cancer means the individual is faced with the potential of lifelong illness and death. The individual concerned feels stigmatised by the diagnosis and is classified as belonging to an illness group.

The findings from this study indicate individuals who have been diagnosed with colorectal cancer need a forum for discussion where they have the opportunity to talk to health care professionals about their concerns. It is necessary to introduce in-depth discussions between patients and health care professionals so that the patient's questions and uncertainties may be addressed and information may be provided. For health care professionals to be able to respond to individuals diagnosed with colorectal cancer, it is necessary to develop communication skills further.

References:

Haase, J. (1987) "Components of courage in chronically ill adolescents: a phenomenological study." *Advances in Nursing Science*, 9 (2): 64-80

Heidegger, M. (1993) *Sein und Zeit*. Tübingen: Max Niemeyer

Heidegger, M. (1996) *Being and Time*. Translated by J. Macquarrie and E. Robinson, Oxford, Blackwell

1. Introduction

Cancer has become one of the most important causes of chronic and acute illnesses in the past few decades (Benner and Wrubel, 1997; Schwarzer, 1997; Faller, 1998; Meerwein and Bräutigam, 1998; Pestalozzi, 2000). Therefore it is not surprising that oncology is now a field of extensive research encompassing both qualitative and quantitative studies. Quantitative studies in oncology have illuminated the effects of newly developed medications and treatments for people diagnosed with cancer (Habr-Gama, Santino and de Souza, 1998; Redmond, 2000; Semmens, Platell, Threlfall and Holman, 2000). Qualitative studies have elucidated the ways of coping and experiences of people diagnosed with cancer (Kesselring, 1987; Burton, 1991; Käppeli, 1998; Baldegger, 2001). Breast cancer has been a major research interest in recent years (Schwarz and Hornburg, 1994). Findings from this research have provoked in-depth changes in prevention and treatment of breast cancer. Screening has become an important measure to diagnose breast cancer at an early stage. In most instances malignancy can be effectively treated. In addition to breast cancer, intestinal cancer is considered one of the most frequent causes of death (Haller, 1994; Courneya and Friedenreich, 1997; Redmond, 2000; Semmens, Platell, Threlfall and Holman, 2000). Its incidence has increased over the past decade. One of the main types of intestinal cancer is colorectal cancer. Its cause remains largely unknown. The influence of malnutrition has been considered to have a major influence on the development of colorectal cancer. However, conclusive evidence has not yet been provided (Eichholzer, 2001). It has been demonstrated that there is a hereditary component to the incidence of colorectal cancer. Some cases of colorectal polyposis seem to lead to the development of colorectal cancer. However, colorectal cancer is often only discovered by chance. Research is targeted toward tests that diagnose colorectal cancer at an early stage (Hess, 2001). In Switzerland, the Swiss Cancer League has contributed to increasing the awareness of Swiss people about the possibility of developing colorectal cancer. The Swiss Cancer League attempts to advocate a healthy diet and engagement in sports activities through information leaflets in order to promote healthy lifestyles that may combat the development of cancer.

Having to tell a patient that they have been diagnosed with cancer seems to be an issue of high interest in medical, nursing and psychological literature. In the past decade, there have

---

[358] To better distinguish the Heideggerian terms from everyday language they are written with capital letters, including the term Existential.

been numerous publications explicating the difficulties that medical professionals have in breaking bad news to cancer patients (Buckman, 1984; Burton, 1991; Campbell, 1994; Glaus, Jungi and Senn, 1997; Faller, 1998; Redmond, 2000; Sahay, Gray and Fitch, 2000). Ways of solving the difficulties associated with breaking bad news and improving the process of conveying the diagnosis to the patient have been described and advocated in literature. However, significant changes do not seem to have occurred in relation to the process of breaking bad news. Breaking bad news remains a sensitive issue for medical professionals.

Receiving a diagnosis of colorectal cancer and what it means to the human being concerned has not been of much interest. In Switzerland, Haller (1994) conducted a study using a grounded theory approach to illustrate the impact of colorectal cancer on the life and social world of the human being. In total 36 patients, in various stages of colorectal cancer, were interviewed. Analysis exposed the importance of 'being active' within which the following four basic categories.

- I am able ("ich kann")
- I am still able ("ich kann noch")
- I am able again ("ich kann wieder")
- I can do it new ("ich kann neu")

The four basic categories signified the degree of impairment an individual with colorectal cancer is confronted with and how the individual evaluates the impairment. Six different types of illness management and the return to everyday life were identified from the data. The size of the malignant growth was important in the management of the illness, as it influenced treatments and therefore impacted on body changes directly. Additionally, the management of the individual experiencing changes was of importance to illness management. A single intervention with rapid restoration was considered less impact on the individual's life than several interventions that could mean a lengthy restoration.

Although Haller (1994) illustrated in detail the impact of a diagnosis of colorectal cancer on an individual's life, little information was provided about the time-span between diagnosis and initial treatments or the impact on everyday life. A need for a more in-depth investigation into the experience of having received a diagnosis of colorectal cancer and its influence on the life of an individual was identified. My study was conducted in the qualitative paradigm assuming a phenomenological approach. It attempts to illustrate the Dasein of colorectal cancer.

2. Theoretical Framework

A phenomenological approach was chosen for the research design. Heidegger's philosophy was chosen as the theoretical framework to underpin the research perspective. Its orientation toward the individual human being was considered a fundamental requirement in the philosophy. Heidegger's philosophy attempts to describe human existence on an ontological level. To illustrate the Existentials that are fundamental structures of Dasein, Heidegger draws on ontic experiences of the human being. The characteristics of Heidegger's Ontology of Dasein support the phenomenological approach chosen to investigate the lived experience of having received a diagnosis of colorectal cancer and its effect on the life of and meaning for the human being.

Introducing all of Heidegger's philosophy is not possible in this brief paper. Not all of the Existentials are relevant to this study. The following Existentials have been identified as being important to the understanding of the Dasein of colorectal cancer and its findings: Being-in-the-world, States-of-mind, Understanding, Being-with, Solicitude, the They-Self, Authenticity and Inauthenticity, Care and Temporality and Being-towards-Death and Death.

3. Design and Subjects

The study was conducted in Switzerland. To gain entry to the study environment, it was necessary to gain ethical approval to undertake the research by applying for permission to undertake the study from one hospital ethics committee and to liase with the head of two other hospitals. In total, 15 patients were approached which had been admitted to the surgical departments of one of these three hospitals. Each of these patients had been diagnosed with colorectal cancer of not more than six months ago. All patients had to undergo surgery for removal of the cancerous growth. Over all, seven patients agreed to participate in the study. They were willing to talk about their experiences of having been diagnosed with colorectal cancer. Of the seven patients participating in the study, four were female and three male. Subsequent to data collection, two of the seven patients died in the last year. One of them died from cancer and the other died of a heart condition.

Over more than twelve months, a variable amount of interviews were conducted with the patients according to their wishes. The patients decided when and where the interviews would take place. They also chose what they would talk about, how long the interview would last. In some instances, patients and I would discuss their feelings and concerns over the telephone. The length of the interviews generally depended on the condition of the patient's health and their life situation.

Participation in the study was voluntary. No payments were made to any participants. Patients were told they could withdraw from the study at any time without any repercussions and that confidentiality about what they told me would be maintained. Before the initial contact with the patient, the physician in charge of the patient had to sign a letter of consent. At the initial contact, the patients were given written information about the study. Following the information the patients were asked to sign a letter of consent. The initial contact usually resulted in an interview that was included in the research data as field notes. All subsequent contacts were made as the patients wished it. As stated previously, patients determined the dates, times and location for the interviews. The patients also decided about when the last interview would take place. The shortest time frame of interviewing spanned a 6-month period and the longest period was 13 months.

4. Data Analysis and Findings

Remaining true to the tenants of phenomenology meant adherence to Heidegger's Ontology of Dasein and its Existentials. Hence, it was decided that computer-supported analysis or fragmentary analysis such as content analysis would not suit the research design. Therefore, Colaizzi's eight-step process of data analysis and synthesis as described by Haase (1987) was adopted. The eight steps appeared to be readily applicable to analysis of data derived from the interviews. Each step in the process was clear and concise. The amount of data was substantial; therefore, it was necessary to engage in preliminary analysis before the identification of categories as delineated in Heidegger's Existentials could be determined. In the process of analysis, the data were reduced to narrative texts comprising the most significant statements. Subsequently the texts were synthesised into the themes of illness, family and medical personnel. From there, the analytic process as described by Haase (1987) was set in motion. In the process of synthesis, 'The Omnipresence of Cancer' emerged as the overarching category with two underpinning sub-categories titled 'Toward Authentic Dasein' and 'Mapping Out The Future'. Each of the sub-categories were comprised of Heidegger's Existentials represented by 'Uncertainty, Transitoriness and Locus of Control.'

The sub-category of 'Toward Authentic Dasein' encompasses the illness experience and its impact on the patients' attitude and view toward life. Receiving a diagnosis of cancer created a sense of 'Uncertainty' because the patients considered it to be life threatening. Subsequently the diagnosis and illness experience provoked deep fear and anxiety. Patients realised the finality of their life and recognised the 'Transitory' nature of their existence. Power shifted from the patients being able to make decisions on their own to allowing others their Locus of Control. Decisions were made for the patients because they felt powerless to make their own decisions as it related to the treatment of their disease. The patients struggled to find a way to deal with their strong emotions of anxiety and fear. In recognition of the 'Transitory' nature of life, they were led to question their beliefs and attitudes towards life. Priorities that the patients had set according to previous goal attainment and to their understanding of the meaning of life were challenged by the illness experience. The patients had to develop coping strategies to deal with the impact of the illness on their lives. These processes were set in motion directly after having received the diagnosis of colorectal cancer and sustained them 'Toward their Authentic Dasein.'

The sub-category of 'Mapping Out The Future' describes the patients' decision to take control of their lives and to return to some semblance of normality. 'Mapping Out The Future' encompasses the patients making changes in their priorities, as well as changes in their outlook on life. Because the patients' future goals were challenged by having received a diagnosis of cancer and the illness experience, patients reflected on how they could once again take control of their lives and have a better Dasein. Hence, the patients adapted their behaviours and outlook to the new life situation. In some instances this means that patients chose in the process of taking back their 'Locus of Control' to reject chemotherapy and radiotherapy even though they knew this could shorten their life. Due to their perception of the 'Transitory' nature of their Dasein, they chose to be comfortable in the time they had remaining, whilst other patients chose to accept chemotherapy and radiotherapy in the hope of extending their Dasein as long as possible.

5. Conclusion

'Uncertainty, Transitoriness and Locus of Control' are representative of Heidegger's Existentials. A patient's State-of-mind, Understanding of the illness, Being-with-others and being alone are woven into the fabric of the illness experience. An inability to take control leads the patients to give over control to others who decide for the patient what is 'best' in relation to management of the illness. During the illness process, patients recognise their Temporality, Being-towards-Death and the potential of death. Thus, in 'Toward Authentic Dasein' the diagnosis of cancer has an overwhelming impact on the patients' moods and their understanding of life. The diagnosis threatens the very foundation of their understanding of Being-in-the World; their Dasein. As patients begin to take control of their lives once again in 'Mapping Out The Future', patients make decisions about undergoing further treatments. Regardless of whether the cancer is 'cured' or 'palliative care' is chosen, the diagnosis of cancer becomes a part of the patient's life. It becomes Omnipresent.

In this study, all of the patients were happy to have been given the opportunity to talk about their experiences of having received a diagnosis of cancer with me. Although, some of the patients had been offered the opportunity to talk to a psycho-oncologist, they welcomed the platform the study offered them. They considered the platform a forum for discussion and a way of reflecting on their understanding of their life situation. In some cases, the platform offered by the study was a way of dealing with difficulties (either their own or those of their family) of accepting the life-threat that a diagnosis of cancer meant.

In the current health care setting where the turnover of patients is high and time is considered to be precious, a platform to discuss experiences needs to be offered to patients. The concept of true presence seems to be of relevance here. It can provide health care professionals an opportunity to listen and to empathise with the patient. This can assist the patient to deal with their 'Uncertainty' and regain their 'Locus of Control' in the midst of 'The Omnipresence of Cancer.'

References

Baldegger, E., (2001) "Bewältigung/Coping." (pp. 125-143) In: S. Käppeli (ed.) *Pflegekonzepte - Phänomene im Erleben von Krankheit und Umfeld.* Band 3. Bern: Hans Huber.

Benner, P., and Wrubel, J., (eds.), (1997) *Pflege, Stress und Bewältigung. Gelebte Erfahrung von Gesundheit und Krankheit.* Aus dem Amerikanischen von I. Erckenbrecht. Bern: Hans Huber.

Buckman, R., (1984) "Breaking bad news: why is it still so difficult?" *British Medical Journal*, May, 288 (6430): 1597-1599.

Burton, M., V., (1991) "Counselling in routine care: a client centred approach." (pp. 74-93) In: Watson, M., (ed.) *Cancer patient care: psychosocial treatment methods.* Cambridge: Cambridge University Press and BPS (British Psychological Society Books).

Campbell, M., L., (1994) "Breaking bad news to patients." *Journal of the American Medical Association*, April, 271 (13): 1052.

Courneya, K., S., and Friedenreich, C., M., (1997) "Relationship between exercise pattern across the cancer experience and current quality of life in colorectal cancer survivors." *Journal of Alternative and Complementary Medicine*, Fall, 3 (3): 215-226.

Eichholzer, M., (2001) "Die Bedeutung von Ernährung, Gewicht und Sport in der Primärprevention von Krebs." Given at: *5. Internationales Seminar. Onkologische Krankenpflege - Fortgeschrittene Praxis.* Universität St. Gallen: Europäische Schule für Onkologie - Deutschsprachiges Programm.

Faller, H., (1998) *Krankheitsverarbeitung bei Krebskranken.* Göttingen: Verlag für angewandte Psychologie.

Haase, J., (1987) "Components of courage in chronically ill adolescents: a phenomenological study." *Advances in Nursing Science,* 9 (2): 64-80.

Habr-Gama, A., Santino, B., and de Souza, P., M., (1998) "Low rectal cancer: impact of radiation and chemotherapy on surgical treatments." *Diseases of the Colon & Rectum,* 41: 1087-1096.

Haller, D., (1994) *Den Lebensfaden wiederfinden. Zerfall und Aufbau in der Sozialen Welt von Patientinnen und Patienten nach einer Dickdarmkrebserkrankung. Eine empirische Studie nach der Methodologie der Grounded Theory.* Bern: Schweizerische Krebsliga.

Heidegger, M., (1993) *Sein und Zeit.* Tübingen: Max Niemeyer.

Heidegger, M., (1996) *Being and Time.* Translated by J. Macquarrie and E. Robinson. Oxford: Blackwell.

Hess, U., (2001) "Mini-Allotransplants: ein immuntherapeutisches Konzept gegen Lymphome, Leukämien und solide Tumoren." Given at: *5. Internationales Seminar. Onkologische Krankenpflege - Fortgeschrittene Praxis.* Universität St. Gallen: Europäische Schule für Onkologie - Deutschsprachiges Programm.

Glaus, A., Jungi, W., F., and Senn, H., J., (eds.), (1997) *Onkologie für Pflegeberufe.* Stuttgart: Thieme.

Käppeli, S., (1998) *Zwischen Leiden und Erlösung. Religiöse Motive in der Leidenserfahrung von krebskranken Juden und Christen.* Bern: Hans Huber.

Kesselring, A., (1987) *Was bedeuten Krankheit und Unterstützung für Patienten?* Basel: Recom.

Meerwein, F., and Bräutigam, W., (eds.), (1998) *Einführung in die Psycho-Onkologie.* 5. überarbeitete Auflage. Bern: Hans Huber.

Pestalozzi, B., C., (2000) "Vom Umgang mit dem Unumgänglichen." *NZZ - Neue Zürcher Zeitung,* Samstag/Sonntag, Januar 8/9, 6: 93-94.

Redmond, K., (ed.), (2000) *Kolorektales Karzinom - ein Leitfaden für das Pflegepersonal.* NICCI (Nursing in Colorectal Cancer Initiative): EONS (European Oncology Nursing Society) and AstraZeneca UK Limited.

Sahay TB, Gray RE and Fitch M (2000) "A qualitative study of patient perspectives on colorectal cancer." *Cancer Practice,* 8 (1): 38-44.

Schwarz, R., and Hornburg, E., (1994) "15 Bewältigungsstrategien (Coping) bei Tumorerkrankungen." (pp. 219-229) In: A. Margulies, K. Fellinger, T. Kroner und A. Gaisser, (eds.) *Onkologische Krankenpflege.* Berlin: Springer.

Schwarzer, R., (ed.), (1997) *Gesundheitspsychologie. Ein Lehrbuch.* 2. überarbeitete und erweiterte Auflage. Bern: Hogrefe.

Semmens, J., B., Platell, C., Threlfall, T., J., and Holman, C., D., J., (2000) "A population-based study of the incidence, mortality and outcomes in patients following surgery for colorectal cancer in Western Australia." *Australian and New Zealand Journal of Surgery,* January, 70 (1): 11-18.

Publication 5

A paper submitted to the EJON02/022 (European Journal of Oncology Nursing), following a presentation at the First Inaugural Conference of the European Honour Society of Nurses and Midwives at City University in London/Great Britain, 8 March 2002. In review since January 2003.

Title: **The Omnipresence of Cancer (EJON02/022 - Revised text)**

Authors:

Maya Shaha, BSc (Hons), MSc, RN, Doctoral Student, City University - St Bartholomew School of Nursing and Midwifery, London

Carol Lynn Cox, BSc (Hons), PG Dip Ed, MA Ed, MSc, PhD, RN, Professor of Nursing, Advanced Clinical Practice, City University - St Bartholomew School of Nursing and Midwifery, London

Correspondence to:
Professor Carol L. Cox
City University - St Bartholomew School of Nursing and Midwifery
20 Bartholomew Close
West Smithfield
London EC1A 7QN
Phone: 020-7040-5812 (Work)
Fax:: 020-7040-5717
E-Mail: C.L.Cox@city.ac.uk

Offprint Requests:
Professor Carol L. Cox
(Word Processing Format: Word Document)

Abstract

The research described in this article was undertaken in partial fulfilment of a PhD in Nursing at City University, London (UK). The study addressed the phenomena of living with a diagnosis of colorectal cancer. The incidence of colorectal cancer has increased over the past few decades. Reasons for the trend have been tentatively attributed to malnutrition, a sedentary lifestyle and hereditary factors. Rationale for undertaking the research was that a need to describe the experience of living with a diagnosis of colorectal cancer and what this means to the individual concerned was identified. To explore the lived experience of colorectal cancer a phenomenological study was developed based on Heidegger's philosophy as presented in his seminal work 'Being and Time' (1993; 1996). Seven patients diagnosed with colorectal cancer were interviewed over a time-span of thirteen months. Patients participating in the study were recruited from three Swiss hospitals.

Data were analysed by following Colaizzi's eight step process as cited in Haase (1987: 66-67). Analysis identified the main category: 'The Omnipresence Of Cancer' and two subcategories: 'Towards Authentic Dasein' and 'Mapping Out The Future'. Constructs underpinning the first sub-category are Fear[359] (Heidegger, 1993: 140ff; 1996: 179ff) and anxiety (Heidegger, 1993: 184ff; 1996: 228ff). The second sub-category is based on Existential Understanding of Dasein[1] (Dasein means human existence or being.) (Heidegger, 1993: 142ff; 1996: 182ff) and hope. It was demonstrated that having received a diagnosis of cancer means the individual is faced with the potential of lifelong illness and death. The individual concerned feels stigmatised by the diagnosis and is classified as belonging to an illness group.

The findings from this study indicate individuals who have been diagnosed with colorectal cancer need a platform for discussion where they have the opportunity to talk with health care professionals about their experiences and concerns. It is necessary to introduce in-depth discussions between patients and health care professionals so that the patient's questions and uncertainties may be addressed and information may be provided. For health care professionals to be able to respond to individuals diagnosed with colorectal cancer, it is necessary to develop effective communication skills that can facilitate catharsis and understanding.

KEY WORDS:

Diagnosis

Stigmatised

Uncertainty

Transitoriness

Locus of Control

Dasein

Introduction

Cancer has become one of the most important causes of chronic and acute illness in the past few decades (Benner and Wrubel, 1997; Schwarzer, 1997; Faller, 1998; Meerwein and Bräutigam, 1998; Pestalozzi, 2000). Therefore it is not surprising that oncology is now a field of extensive research encompassing both qualitative and quantitative studies. Quantitative studies in oncology have illuminated the effects of newly developed medications and treatments for people diagnosed with cancer (Habr-Gama, Santino and de Souza, 1998; Redmond, 2000; Semmens, Platell, Threlfall and Holman, 2000). Qualitative studies have elucidated the way people cope following a diagnosis of cancer (Kesselring, 1987; Burton, 1991; Käppeli, 1998; Baldegger, 2001).

In this article a research study undertaken in Switzerland is described that explicates the patient's experience following receipt of a diagnosis of colorectal cancer. Heidegger's (1993, 1996) philosophy was chosen as the theoretical framework to underpin the research perspective. Through a phenomenological approach, two sub-categories: 'Towards Authentic Dasein' and 'Mapping Out the Future' were discerned. The two sub-categories comprise the main category: 'The Omnipresence of Cancer'. Constructs underpinning the first sub-category are Fear[360] (Heidegger, 1993: 140ff; 1996: 179ff) and anxiety (Heidegger, 1993: 184ff; 1996: 228ff). The second sub-category is based on Existential Understanding of Dasein[1] that is the understanding of human existence or being (Heidegger, 1993: 142ff; 1996: 182ff) and hope.

---

[359] To better distinguish the Heideggerian terms from everyday language they are written with capital letters, including the term Existential.

[360] To better distinguish the Heideggerian terms from everyday language they are written with capital letters, including the term Existential.

Literature Review, Rationale and Aim of the Research

Intestinal cancer is one of the most frequent causes of death following a diagnosis of cancer (Haller, 1994; Courneya and Friedenreich, 1997; Redmond, 2000; Semmens, Platell, Threlfall and Holman, 2000). Its incidence has increased over the past decade. One of the main types of intestinal cancer is colorectal cancer. Its cause remains largely unknown. Malnutrition has been considered to have an impact on the development of colorectal cancer. However, conclusive evidence as to why malnutrition influences the development of colorectal cancer has not yet been determined (Eichholzer, 2001). It has been demonstrated that there is a hereditary component to the incidence of colorectal cancer, as has been evidenced in some family groups (Semmens, Platell, Threlfall, and Holman, 2000). Some cases of colorectal polyposis seem to lead to the development of colorectal cancer. However colorectal cancer is often only discovered by chance. Research has been targeted toward tests that diagnose colorectal cancer at an early stage (Hess, 2001). In Switzerland, the Swiss Cancer League has worked on increasing awareness about the possibility of developing colorectal cancer by encouraging people to engage in healthy living that includes the maintenance of a healthy diet and exercise. This is done primarily through the distribution of leaflets (Shaha, 2002).

Having to tell a patient that they have been diagnosed with cancer seems to be an issue of high interest in medical, nursing and psychological literature. In the past few decades, there have been numerous publications explicating the difficulties that medical professionals have in breaking bad news to cancer patients (Buckman, 1984; Burton, 1991; Campbell, 1994; Glaus, Jungi and Senn, 1997; Faller, 1998; Redmond, 2000; Sahay, Gray and Fitch, 2000). Ways of solving the difficulties associated with breaking bad news and improving the process of conveying the diagnosis to the patient have been described and advocated in literature. However, as literature has demonstrated, significant changes do not seem to have occurred in relation to the process of breaking bad news (Redmond, 2000; Sahay, Gray and Fitch, 2000). Breaking bad news remains a sensitive issue for medical professionals.

Receiving a diagnosis of colorectal cancer and what it means to the individual diagnosed with the disease has not been much of a research interest. In Switzerland, Haller (1994) undertook a study using a grounded theory approach to illustrate the impact of colorectal cancer on an individual's life and social world. In total 36 patients, in various stages of colorectal cancer, were interviewed. Analysis exposed the importance of 'being active' in the following four basic categories:

- I am able ("ich kann")
- I am still able ("ich kann noch")
- I am able again ("ich kann wieder")
- I can do it new ("ich kann neu").

The four basic categories signify the degree of impairment an individual with colorectal cancer has. The categories also reflect how an individual who has colorectal cancer personally evaluates the impairment. Six different types of illness management and the return to everyday life were identified from the data. The size of the malignant growth was important in management of the illness, as it influenced treatments and therefore impacted on body changes directly. Additionally, the healthcare management of the individual experiencing changes was of importance. A single intervention with rapid restoration was considered less of an impact on the individual's life than several interventions that could mean a lengthy recovery.

Although Haller (1994) illustrated in detail the impact of a diagnosis of colorectal cancer on an individual's life in relation to their perception of impairment, little information was provided about an individual's experiences in the time-span between diagnosis and initial treatments and what this meant to individuals or the impact on their everyday lives. A need for an in-depth investigation into the experience of having received a diagnosis of colorectal cancer and its influence on the lives of individuals was identified. The research described in this article was conducted in the qualitative paradigm and as previously indicated, assumed a phenomenological approach. The aim of the study therefore was to discern the experiences of individuals following the receipt of a diagnosis of colorectal cancer and what the diagnosis and experience meant to them. In relation to Heidegger's philosophy the lived experience of colorectal cancer would be termed, the 'Dasein' (Heidegger, 1993, 1996) of colorectal cancer.

Theoretical Framework

Heidegger's (1993, 1996) philosophy was chosen as the theoretical frame of reference in the research because of its orientation toward the individual human being in relation to human existence; that is how we exist in the world. Heidegger's philosophy attempts to describe human existence on an ontological level. To illustrate this, Heidegger describes Existentials (ways of being) that are fundamental features of Dasein (human existence or being), by drawing on the (ontic) every day experiences of the human being's life. The characteristics of Heidegger's philosophy support the research method (phenomenological approach) chosen to investigate the lived experience of having received a diagnosis of colorectal cancer and its effect on the life of and meaning for the human being as will be seen further on in this article.

Introducing all of Heidegger's philosophy is not possible in this article. In addition, not all of the Existentials (ways of being) delineated in Heidegger's writings are relevant to the study described here. The following Existentials have been identified as being important to understanding the Dasein of colorectal cancer (How an individual exists following a diagnosis of colorectal cancer). These are: Being-in-the-world (our existence in the world), State-of-mind (our moods), Understanding (how we interpret, comprehend and make decisions), Being-with (being with others), Solicitude (being there for others), the They-self (how we live in society), authenticity (making decisions unique to our own existence) and inauthenticity (making decisions that are socially congruent), temporality (the state or quality of time) and care and finitude (things that matter to us in our temporality) and death.

Method (Design, Subjects and Colaizzi's Analytical Data Analysis Procedure)

The study was conducted in Switzerland. To gain entry to the study environment, it was necessary to obtain ethical approval by applying for permission to undertake the study from one hospital ethics committee and to liase with the head of two other hospitals. In total, 15 patients were approached who had been admitted to the surgical departments of one of these three hospitals. Each of the patients had been diagnosed with colorectal cancer within the past six months. All patients underwent surgery for removal of a cancerous growth. Over all, seven patients agreed to participate in the study. They were willing to talk about their feelings and experiences following their diagnosis of colorectal cancer. Of the seven patients participating in the study, four were female and three male. Subsequent to data collection, two of the seven patients died. One of them died from the cancer itself and the other died of a heart condition. The main reason given by the eight patients that refused to participate was that they did not want to talk about the cancer after they left the hospital. They were happy to be interviewed in hospital, however once discharged they did not want further reminder of their cancer or hospitalisation.

Over approximately thirteen months, a variable amount of interviews were conducted with the patients according to their wishes. For the first month, patients were interviewed every week, then in the next two months once every two weeks and finally once a month unless the patients wished to be seen more often. The patients decided when and where the interviews would take place. They also chose what they would talk about and how long the interview would last. In some instances patients would telephone to discuss their feelings and concerns in between scheduled interviews or when they felt they could not be seen. The length of interviews generally depended on the condition of the patient's health and their life situation.

Participation in the study was entirely voluntary. No payments were made to any participants. Patients were told they could withdraw from the study at any time without any repercussions and that confidentiality about what they said would be maintained. Before the initial contact with the patient, the doctor responsible for the patient signed a letter of consent giving permission for the patient to be interviewed. At the initial contact, the patients were given written information about the study. Following presentation of the information the patients who agreed to participate in the study were asked to sign a letter of consent. The initial contact usually resulted in an interview that was included in the research data as field notes. All subsequent contacts were made as the patients wished. As stated previously, patients determined the dates, times and location for the interviews. The patients also decided when the last interview would take place. The shortest time frame of interviewing spanned a 6-month period and the longest period was 13 months.

Phenomenology allows for a wide range of methods for data collection, such as interviews, tape recording interviews and data analysis. Colaizzi's method of data analysis as described by Haase (1987) was employed in this study and involves the following steps:

- Acquisition of a sense of meaning through listening to and transcribing the tapes.
- Extraction of significant statements.
- Formulation of significant statements into a more general restatement.
- Formulation of a statement of meaning and validation of that meaning by a panel of experts.
- Organisation of formulated meanings into themes, theme clusters, and theme categories. (The theme categories that emerged were one main category, 'The Omnipresence of Cancer' and two sub-categories, 'Toward Authentic Dasein' and 'Mapping Out The Future'.)
- Integration of themes into an exhaustive description of the phenomena of interest.
- Formulation of the statement of the essential structure (The essential structure is 'The Omnipresence of Cancer').
- Validation of the essential structure by study participants.

In this study, two healthcare experts in the field of oncology nursing and an academic with an extensive background in nursing research served as the expert panel. All of the study participants, who were living at the conclusion of the formulation of the statement of the essential structure, validated the statement that is 'The Omnipresence of Cancer'.

Findings and Discussion

Remaining true to the tenants of phenomenology meant adherence to Heidegger's (1993, 1996) Existentials (ways of being). Hence, it was decided that computer-supported analysis or fragmentary analysis such as content analysis would not suit the research design. Colaizzi's process of data analysis and synthesis as described by Haase (1987) was applicable to analysis of data derived from the interviews. The amount of data was substantial; therefore, it was necessary to engage in preliminary analysis before the identification of categories as delineated in Heidegger's Existentials could be determined. In the process of analysis, the data were reduced to narrative texts comprising the participants' most significant statements. Subsequently the texts were synthesised into themes of the illness experience and relationships with family and medical personnel. Following this stage, the analytic process as described by Colaizzi in Haase's (1987) publication was set in motion. As shown in the method section of this article, 'The Omnipresence of Cancer' emerged as the main category. Two (underpinning) sub-categories titled 'Toward Authentic Dasein' and 'Mapping Out The Future' were comprised of Heidegger's Existentials. These were represented in the constructs of 'Uncertainty, Transitoriness and Locus of Control' within each of the sub-categories.

'Toward Authentic Dasein'

The sub-category of 'Toward Authentic Dasein' encompasses the illness experience and its impact on the patients' attitude and view toward life. Receiving a diagnosis of cancer created a sense of 'Uncertainty' because the patients considered it to be life threatening. Subsequently the diagnosis and illness experience provoked deep fear and anxiety. Patients realised the finality of their life and recognised the 'Transitory' nature of their existence. Power shifted from the patients being able to make decisions on their own to allowing others their Locus of Control. Decisions were made for the patients because they felt powerless to make their own decisions as it related to the treatment of their disease. The patients struggled to find a way to deal with their strong emotions of anxiety and fear. In recognition of the 'Transitory' nature of life, they were led to question their beliefs and attitudes towards life. Priorities that the patients had set according to previous goal attainment and to their understanding of the meaning of life were challenged by the illness experience. The patients had to develop coping strategies to deal with the impact of the illness on their lives. These processes were set in motion directly after having received the diagnosis of colorectal cancer and sustained them 'Toward their Authentic Dasein.' Some examples of narrative translated from patients' transcripts after receipt of their diagnosis and initiation of treatment reflects the following:

> *I felt like a calf brought for slaughtering...You don't know what they will do. You simply go there and hope for the best.* (Translated from original transcript).

> *I knew something was wrong. I didn't want my candle* (my life) *to be extinguished before Christmas.* (Translated from original transcript).

> *I am so afraid...I don't know what is going to happen...The doctors will tell me what to do.* (Translated from original transcript).

> *I am used to taking my life in my own hands. Nobody tells me to do anything. Since I have been ill, all has changed. I cannot make my own decisions anymore. Everything is given.* (Translated from original transcript).

This narrative reflects the patient's experience of fear, uncertainty about what will happen to them, a sense of their experience at the time (transitoriness) and a giving up of their locus of control to others. The fear and anxiety demonstrated in these statements is reflective of Heidegger's Existentials, Being-in-the-world, State-of-mind and Understanding.

'Mapping Out The Future'

The sub-category of 'Mapping Out The Future' describes the patients' decision to take control of their lives and to return to some semblance of normality. 'Mapping Out The Future' encompasses the patients making changes in their priorities, as well as changes in their outlook on life. Because the patients' future goals were challenged by having received a diagnosis of cancer and the illness experience, patients reflected on how they could once again take control of their lives and experience a better Dasein. Hence, the patients adapted their behaviours and outlook to the new life situation. In some instances this meant that patients chose in the process of taking back their 'Locus of Control' to reject chemotherapy and radiotherapy even though they knew this could shorten their life. Due to their perception of the 'Transitory' nature of their Dasein, they chose to be comfortable in the time they had remaining, whilst other patients chose to accept chemotherapy and radiotherapy in the hope of extending their Dasein as long as possible. Some examples of narrative translated from patients' transcripts reflects the following:

> *Then I thought, For God's sake, I hope one of those wigs will suit me...and it did suit me. That's the one I have now...I am feeling better about myself.* (Translated from original transcript).

> *I am very hopeful...But I will have to wait and see. At each screening the thoughts* (of cancer returning) *won't be far away. Now I am looking forward and know what I must do to stay well.* (Translated from original transcript).

> *I'm not having any more chemotherapy. I've had enough of sickness. I am going on holiday now and look forward to seeing my family at Christmas.* (Translated from original transcript).

> *It is over for me now. I am not thinking about it anymore. It is like a task that has been completed.* (Translated from original transcript).

This narrative reflects the patients' experience of coming to terms with their illness, having a better understanding about what will happen to them, a sense of their experience at the time (transitoriness) and regaining their locus of control. Heidegger's Existentials, Being-in-the-world, State-of-mind, Understanding, Being-with, Solicitude, the They-self, authenticity and inauthenticity, temporality and the possibility of death are reflected in the participants' statements.

Conclusion - The Omnipresence Of Cancer

'Uncertainty, Transitoriness and Locus of Control' are representative of Heidegger's Existentials associated with Dasein. A patient's state of mind, understanding of the illness, being with others and considering the things that matter to them are woven into the fabric of the illness experience. An inability to take control leads patients to give over control to others who decide for the patient what is 'best' in relation to management of the illness. During the illness process, patients recognise their temporality, finitude and the potential of death. Thus, in 'Toward Authentic Dasein' the diagnosis of cancer has an overwhelming impact on the patient's moods and their understanding of life. The diagnosis threatens the very foundation of their understanding of Being-in-the World: their Dasein. As patients begin to take control of their lives once again in 'Mapping Out The Future', patients make decisions about undergoing further treatments. Regardless of whether the patient is 'cured', in a medical sense, or 'palliative care' is chosen, the diagnosis of cancer becomes a part of the patient's life. It becomes Omnipresent.

In this study, all of the participants relished the opportunity to talk about their experiences of having received a diagnosis of cancer. Although, some of the patients had been offered the opportunity to talk to a psycho-oncologist, they welcomed the platform the study offered them. They considered the platform a forum for discussion and a way of reflecting on their understanding of their life situation. In some cases, the platform offered by the study was a way of dealing with difficulties (either their own or those of their family) and accepting the life-threat that a diagnosis of cancer means.

In the current health care setting where the turnover of patients is high and time is considered to be precious, a platform to discuss experiences and concerns needs to be offered to patients. The concept of true presence seems to be of relevance here. It can provide health care professionals an opportunity to listen and to empathise with the patient. This can assist the patient to deal with their 'Uncertainty' and regain their 'Locus of Control' in the midst of 'The Omnipresence of Cancer.'

References

Baldegger, E., (2001) "Bewältigung/Coping." (pp. 125-143) In S. Käppeli (ed.) *Pflegekonzepte - Phänomene im Erleben von Krankheit und Umfeld.* Band 3. Bern: Hans Huber.

Benner, P., and Wrubel, J., (eds.), (1997) *Pflege, Stress und Bewältigung. Gelebte Erfahrung von Gesundheit und Krankheit.* Aus dem Amerikanischen von I. Erckenbrecht. Bern: Hans Huber.

Buckman, R., (1984) "Breaking bad news: why is it still so difficult?" *British Medical Journal*, May, 288 (6430): 1597-1599.

Burton, M., (1991) "Counselling in routine care: a client centred approach." (pp. 74-93) In: M. Watson (ed.) *Cancer patient care: psychosocial treatment methods.* Cambridge: Cambridge University Press and BPS (British Psychological Society Books).

Campbell, M., (1994) "Breaking bad news to patients." *Journal of the American Medical Association*, April, 271 (13): 1052.

Courneya, K., and Friedenreich, C. (1997) "Relationship between exercise pattern across the cancer experience and current quality of life in colorectal cancer survivors." *Journal of Alternative and Complementary Medicine*, Fall, 3 (3): 215-226.

Eichholzer, M., (2001) "Die Bedeutung von Ernährung, Gewicht und Sport in der Primärprevention von Krebs." Given at: *5. Internationales Seminar. Onkologische Krankenpflege - Fortgeschrittene Praxis.* Universität St. Gallen: Europäische Schule für Onkologie - Deutschsprachiges Programm.

Faller, H., (1998) *Krankheitsverarbeitung bei Krebskranken.* Göttingen: Verlag für angewandte Psychologie.

Habr-Gama, A., Santino, B., and de Souza, P., M. (1998) "Low rectal cancer: impact of radiation and chemotherapy on surgical treatments." *Diseases of the Colon & Rectum*, 41: 1087-1096.

Haller, D., (1994) *Den Lebensfaden wiederfinden. Zerfall und Aufbau in der Sozialen Welt von Patientinnen und Patienten nach einer Dickdarmkrebserkrankung. Eine empirische Studie nach der Methodologie der Grounded Theory.* Bern: Schweizerische Krebsliga.

Haase, J., (1987) "Components of courage in chronically ill adolescents: a phenomenological study." *Advances in Nursing Science*, 9 (2): 64-80.

Heidegger, M., (1993) *Sein und Zeit*. Tübingen: Max Niemeyer.

Heidegger, M., (1996) *Being and Time*. Translated by J. Macquarrie and E. Robinson, Oxford, Blackwell.

Hess, U., (2001) "Mini-Allotransplants: ein immuntherapeutisches Konzept gegen Lymphome, Leukämien und solide Tumoren." Given at: *5. Internationales Seminar. Onkologische Krankenpflege - Fortgeschrittene Praxis*. Universität St. Gallen: Europäische Schule für Onkologie - Deutschsprachiges Programm.

Glaus, A., Jungi, W., F., and Senn, H., J. (eds.), (1997) *Onkologie für Pflegeberufe*. Stuttgart: Thieme.

Käppeli, S., (1998) *Zwischen Leiden und Erlösung. Religiöse Motive in der Leidenserfahrung von krebskranken Juden und Christen*. Bern: Hans Huber.

Kesselring, A., (1987) *Was bedeuten Krankheit und Unterstützung für Patienten?* Basel: Recom.

Meerwein, F., and Bräutigam, W., (eds.), (1998) *Einführung in die Psycho-Onkologie*. 5. überarbeitete Auflage. Bern: Hans Huber.

Pestalozzi, B., C., (2000) "Vom Umgang mit dem Unumgänglichen." *Neue Zürcher Zeitung*, Samstag/Sonntag, Januar 8/9, 6: 93-94.

Redmond, K., (ed.), (2000) *Kolorektales Karzinom - ein Leitfaden für das Pflegepersonal*. NICCI (Nursing in Colorectal Cancer Initiative): EONS (European Oncology Nursing Society) and Astra Zeneca UK Limited.

Sahay T., Gray R., and Fitch M., (2000) "A qualitative study of patient perspectives on colorectal cancer." *Cancer Practice*, 8 (1): 38-44.

Schwarzer, R., (ed.), (1997) *Gesundheitspsychologie. Ein Lehrbuch*. 2. überarbeitete und erweiterte Auflage. Bern: Hogrefe.

Semmens, J., Platell, C., Threlfall, T., and Holman, C. (2000) "A population-based study of the incidence, mortality and outcomes in patients following surgery for colorectal cancer in Western Australia." *Australian and New Zealand Journal of Surgery*, January, 70 (1): 11-18.

Shaha, M., (2002) "The Omnipresence of Cancer." (pp. 130-137) In: Cox, C. (ed.) *Enhancing the Practice Experience*. Bournemouth: Nursing Praxis International.