The role of social interactions in learning to cope with cancer : an existential sociological study of an online support group forum

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THE ROLE OF SOCIAL INTERACTIONS IN LEARNING TO COPE WITH CANCER: AN EXISTENTIAL SOCIOLOGICAL STUDY OF AN ONLINE SUPPORT GROUP FORUM

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ABSTRACT

To many, cancer is a life-changing crisis that disrupts the flow of many activities, aspirations, plans, and fulfillment of many individuals. Some orthodox existential and psychological findings testify to how being ridden with cancer may lead to stagnation, hopelessness, pessimism, and a disavowal of responsibility towards one's life. However, such findings are contradicted by new findings that suggest that the experience of cancer may lead to adaptation through positive cancer-coping beliefs. Despite this, such new findings involve explanations which are mostly endogenous in nature, examining such growth strictly from the psychological perspective of the individual, while neglecting exogenous factors such as social interactions. In this study, social interactions were found to play a pivotal role on an online cancer support group in facilitating the cancer-coping beliefs of patients from a state of powerlessness and hopelessness upon cancer diagnosis, to a stage of acceptance and embrace of life. To analyse this, various literature in existential sociology and social constructivism have been used to study the exogenous impact of social interactions on the former. Methodologically, the threads and posts of cancer sufferers and survivors on an online cancer support group forum have been studied through qualitative content analysis.

Introduction

Chapter 1

“Time is shortening. But every day that I challenge this cancer and survive is a victory for me.” –

Ingrid Bergman, Actress, from an interview

In our daily lives, we rarely contemplate death. Patients of late-stage (i.e., Stage IV) breast cancer, however, face the prospects of death — sometimes imminent death — daily, bringing existential discomfort, but also enabling them to view life from new or different angles. Terminal breast cancer patients may give in to life’s vicissitudes, or conversely take a colossal stride toward embracing new possibilities for growth. Confronting terminal cancer may be understood as a life crisis, which has several existential characteristics. First, life crises are sudden and intense, disrupting the flow of life and compelling patients to make choices that may be healthy or unhealthy for the person's life (Jacobsen 2007:71). Second, crises involve losses "that [one] subsequently miss[es],” resulting in a reaction of grief (Jacobsen 2007:73-78). The notion of crisis tests the capacity to accept or confront one's existential facticity¹. Third, crises are "events that due to their critical and dangerous nature, stand out from the continuous flow of life in general" (Bollnow 1966:34). Life crises cross multiple domains, including one’s physical and mental health, career, and social relations. There are thus existential, interpersonal, and financial issues that arise and must be dealt with. Fourth, life crises can "turn lives around" (Denzin 1989:15): they are moments for decision, moments in which victims meet "two or more different possible pathways” (ibid.) that may lengthen a crisis or help the patient to move beyond it. This

¹Facticities, philosophically speaking, are contingencies within a person's life that occur by chance, and in this paper's context, refer to misfortunes such as cancer.

depends in part on the process of existential reflexivity, through which one comes to terms with notions of isolation, meaninglessness and death on the one hand, or of self-awareness, growth and freedom, on the other.

RESEARCH AIMS

In this study I examine social interactions in an online public cancer support forum among people who have experienced cancer-as-life crisis. My interest is in how crisis compels people to seek new meanings of selfhood in the face of death (Tiryakian 1968). Although selves are constantly-evolving and reflexive constructs (Mead 1934), past sociological research has shown that sudden self-transformations may arise from crises involving physical pain (Kotarba 1983) or intense anxiety. Through the use of unobtrusive qualitative content analysis, I explore in particular the interactional processes through which this self-transformation occurs among individuals diagnosed with late-stage breast cancer. Many models of cancer-coping exclude both the social basis of the self and the minutiae of interactions in the existential meaning-making process. Additionally, many models of cancer-coping posit that cancer patients fall into eventual denial, regression and stagnation. I wish to examine how cancer patients confront their illness and endeavour to create purpose and meaning from it. However, rather than conceptualise such growth as deriving strictly from internal psychological processes, I will describe how social interactions among cancer patients and survivors facilitate this. To do this, I first theorize useful connections between existential philosophy and sociology, and then integrate Berger and Luckmann's (1966) concepts of internalisation, externalisation, and objectivation into those connections in order to chart how cancer patients' perceptions towards their illness and

themselves change, and how these changes in turn contributes to a culture of growth and assistance.

Research Questions

My aim is to show how cancer patients grow from denial, pessimism, and despair towards a growth-oriented perspective through the re-definition of the traumatised, cancered self using acceptance and optimism. To achieve this aim, I pose the following research questions:

- 1) Do the studied cancer patients follow a developmental pathway from negativity to positivity during their time on the forum?
- 2) What are the social processes through which people's existential selves and cancer-coping practices are transformed via social interactions?
- 3) How do patients move away from their initial "life crisis" and then transmit what they have learned to others?

Cancer, the Internet, and Online Cancer Support Groups

Cancer, physiologically speaking, is a malignant growth of invasive cells to parts of the body (Defining Cancer 2014). In 2010, around 7.98 million people globally have died of cancer, while in 2008, 12.7 million people in the world were diagnosed with cancer (Jernal et al.

2011:16). Cancer can affect people of all ages, social classes or ethnic backgrounds, though the elderly are particularly susceptible to it.

Many methods of cancer management have focused on its physiological handling, through surgery, radiation therapy, chemotherapy, and palliative care. Counselling may be provided to assuage its psychological impact. However, the role of the internet as an anodyne is still emerging. The availability of the internet allows cancer patients to seek technical information on cancer and its treatment, share their experiences of cancer, and seek support from other online patients. This provides an alternative that can be used parallel to face-to-face interactions. Online cancer social support groups or discussion forums have been recently found to be a significant source of such socio-emotional assistances, which is my primary focus in this study.

Nature of Internet Use

As of 2015, 3.2 billion people, or around 40% of the global population, were online planet-wide (Sanou 2013). Europeans comprise the largest user group (191 million), followed by Asians (187 million), and North Americans (183 million) (Eysenbach 2003:356). It has been estimated that up to 93% of cancer patients use the internet as a whole (Girault et al. 2014). 84% of breast cancer patients were found to be more easily satisfied with online cancer information (Girault et al. 2014). Most English-speaking studies on cancer information-seeking and internet use were made in USA, followed by Canada, Norway, Australia, Sweden, and Ireland (Eysenbach 2003). The internet has provided additional social, emotional, and professional

resources for cancer patients. There are more than 100,000 health-related online sites available (Afshari et al. 2011). Cancer is also one of the top three illnesses that patients and their associated kin seek information (Afshari et al. 2011). As such, convenient internet accessibility has led to a higher degree of utilization by cancer patients, thereby constituting my motive to conduct an investigation of its impact on cancer outcomes.

Breast cancer internet users are significantly younger and better educated (Pereira et al. 2000). 6 times as many college-educated cancer patients use the internet to seek help, compared to the uneducated (Afshari et al. 2011). White households (40.8%), compared to Blacks (19.3%) or Hispanic (19.4%) were more likely to have home access to the internet (Wilson et al. 2003: 136).

Sources of internet use include online cancer communities such as bulletin board forums, mailing lists, online news groups, chat-rooms, and websites (Eysenbach 2003). Schweizer, Krcmar and Leimeister (2006:4471) defined "online communities" as virtual places where people meet and interact, have similar specific interests, and can establish "social and virtual relationships", as defined as "repeated online interactions between two persons" (p. 4471). For this paper, I define online cancer support group forums as online communities offering a bulletin-style system that allows users to view, post, edit, and reply to each other's threads and posts to establish simultaneous "social and virtual relationships" through interactions such as information-sharing, social rapport, emotional support, advice, guidance, aid, counselling, encouragements, and empathy.

Such online forums have a major influence on many users. Some studies of the social networking processes by virtual cancer communities conducted found that participants exchanged technical information on treatment and the illness weekly (Schweizer, Krcmar and Leimeister 2006:4475). In addition to cancer patients, around 60% of patients had family members use the internet to seek cancer information online (Eysenbach 2003; Yakren et al. 2001). Around 80% of messages exchanged involved encouragement, support, vicarious episodes, and personal viewpoints, while 20% included gratitude, jokes, and spiritual seeking (Klemm et al. 1998). Finally, online forums eliminate travelling barriers, and provide anonymity against stigma, embarrassment or sensitivities, (Klemm et al. 2003; Eysenbach 2003; Shaw et al. 2000).

Rather than peripheralise the role of online cancer support groups in the process of cancer treatment, such studies identify social relations and internet technologies as important to the holistic connections among body, mind and spirit. While medical advances may treat neoplastic outgrowths in one's body, the patient is more than her physical form — she is also one with an intricate psyche that can receive solace and rapport through communion with others.

This study involves the examination of an online breast cancer support group that was initiated by a non-profit organisation around 2002 to provide technical information about breast cancer, and to provide an online forum for participants with breast cancer, their kin or friends to participate and share experiences and provide support to each other. There are many different online support groups, but they are all similar in that they offer a bulletin where registered members can view each other's posts and threads, and in turn respond to them publically, or through private messages. Such forums are usually public, which means that non-members can

view the messages on the bulletin, but participation requires registration with a username. Once a person has created a username, he or she can login, and search the databases of the forum, for information regarding the profiles of the forum users or find user threads that the researcher wishes to find.

FACILITATION OF POSITIVE CANCER-COPING BELIEFS ON ONLINE CANCER SUPPORT GROUPS

Online support groups can help facilitate the cancer-coping development of cancer patients on an online cancer support group.

It has been found that online cancer support groups provide emotional catharsis, support, concern, care, technical and treatment information, assistances in medical decision-making, financial provisions, chances for participants to offer empathy towards each other, vent frustration, and seek encouragement from others to cope (Afshari et al. 2011; Gill and Whisnant 2012; Mett 2005; Baker and Wagner 2003; Chiu and Hsieh 2012; Pinheiro and al. 2008; Love and al. 2012; Fontana and de Water 1977). They also empower patients with control, decreases anxiety, improve self-esteem, and provide reassurance (Mills and Sullivan 1999; Im et al. 2007; Ashari et al. 2011). They also provide social capital, role models to follow, and expert advice which reduces their isolation (Love et al. 2012: 557; Madara and White 1997; Bacon et al. 2000). Lastly, supportive interaction on such forums helped users reach "inner strengthening" through "encouragement, support, and consolation" received from similar others on the Internet to cope

with their disease and empower their medical decision-making (Pitts 2004; Yli-uotila, Rantanen and Suominen 2014:121-123).

Therefore, former studies depicted the salubrious role of such online support forum in terms of its psychological and emotional benefits. What would entail cases of social interactions and processes that facilitate the exchange of such information?

Online cancer support forums provide a commonality of vicarious experiences with similar people who "understand what it is like" to have cancer (Laranjeira, Leao & Leal 2013:138). This shared vicarious experience leads to mutual empathy and understanding that made each other feel more involved through a shared "symbolic universe" (Pinheiro et al. 2008:736). Studies of experiences of women with breast cancer in support groups found that patients grew by seeking mostly "positive references and identities" as motivation to overcome their issues, allay their phobias, and re-situate them towards optimism and hope (Pinheiro et al. 2008:736). By emulating more experienced cancer survivors, they were led to "resocialisation and recovery" through the provision of "enormous amount[s] of energy" (p. 736 - 737). Interactions therefore provide validation and support from the similar experiences of others to assist in recovery.

This leads to a "cyclical process of continued conversations" which involves the appraisal, validation, agreement, disagreement and re-evaluation of each other's experiences, which leads to increased existential and emotional awareness through the sharing of stories, feelings, and thoughts towards the commonality in diagnosis and prognosis (Love et al. 2012).

This mutuality in the interpretation of each other's signs of approval produced a flow of continued exchanges that facilitated emotional growth, expression, and honesty, by reinforcing the positive cancer-coping beliefs on the forum through appraisals and positive feedbacks to each other (Laranjeira, Leao & Leal 2013:138). Conversely, some individuals would post negative topics of dolor, overwhelming anxiety, phobias, or isolation, only to have them disaffirmed through re-framing, or consolation. Therefore, through validation and agreement, the socially agreed cancer-coping values that encouraged growth may therefore be internalised, while the less agreed-upon negative coping methods may be discarded.

It is thus possible that more experienced members may exert an influence on the cancer-coping beliefs of inexperienced ones on an online cancer support group, by reframing the negative mentalities of the latter into positivity, through the provision of the aforementioned social processes. Social interactions may thus play a role in modulating individual existential choices in the movement towards growth.

SUMMARY AND CONCLUSION

This study shall employ qualitative content analysis to parse the posts of an online breast cancer support group, in order to study the processes behind the social interactions between members with breast cancer. It shall borrow concepts from existential philosophy, existential sociology, and social constructivism to chart a developmental model on how members are socialised into adorning cancer-coping beliefs. In this thesis, I have attempted to formulate a developmental model that describes how social interaction facilitates cancer-coping among

members of the internet forum I studied. The following chapters provide a detailed exposition of the proposed four developmental steps of (1) realisation, (2) imposition, (3) internalisation, and (4) externalisation with respect to how the cancer-coping stocks of knowledge are learned and passed on to other members.

Literature Review

Chapter 2

I chose to apply existentialism to my research, as it confronts questions of life, death, meaning, purpose, and mortality - important concerns that no individual may ignore. For a cancer patient facing possible annihilation, inquiries over such concepts become more pronounced, magnifying their drive to seek meliorations and act purposefully towards life. This is important, as cancer patients are far from being rational beings - they are feeling and philosophical beings who question their proximity to death, and reason for being. Existential concerns are thus primary and amplified in the cancer patient, which constitutes my main reason in studying existentialism.

According to Heidegger, the fear of death is the fundamental drive that compels one toward making amendments in one's life to imbue meaning into it. Heidegger's and Sartre's existential philosophy shows how man's preoccupation with death, arising from a crisis, thrusts one into changes to meliorate one's life. I shall show how the former's terms can be translated into, and built upon, by the central focus of this thesis - existential sociology.

EXISTENTIAL PHILOSOPHY

Existential philosophers maintain that extrinsic descriptions of ourselves involving things such as social class, race, religion, or occupation fail to deal directly enough with one's being in the world. Heidegger (1962:11-13) argued that, in order to live authentically, a person must confront and work out the meaning of her own existence, or indeed what it means to exist at all.

The core, authentic self that a person must learn to confront, he called “Dasein.” In everyday life however, Dasein is obscured by mundane practices that distract people from developing a deeper understanding of the meaning of life and hinder the self from engaging life's broader meaning and purpose. For individuals faced with a breast cancer diagnosis, the realisation of imminent death prompts them to examine their inner self, realise what they have failed to achieve, and thus focus on intrinsic attainments that are more meaningful than extrinsic occupations that do not realise one's true potential. A person who has never dealt with mortality, from a life-threatening illness may be less inclined to engage in self-reflexivity. *Being-toward-death* or *being-unto-death* are words Heidegger used to describe a person's realisation where death leads to Dasein's annihilation of all possible choices to choose and act from (Heidegger 1962). Death is not just inevitable, but also "essentially and irreplaceably [one's own]" (Heidegger 1962:234-253). From the perspective of existential philosophy then, the tumult and dread that comes from a cancer patient in facing one's being-toward-death is a source of motivation to reflect on one's failings, and work towards meaningful living.

What follows from such a realisation? In "Nausea", Sartre provides a framework to analyse one's growth in face of death. In line with existential and interactionist sociologies, he suggests that the self is not a thing, but a process or becoming that is realised through choice. Freedom is at the heart of Sartre's social philosophy, as he affirms: "I am condemned to be free" (Sartre 1945a:286). In "Being and Nothingness", Sartre wrote that people may not seek to be merely an objectified "thing-in-itself" - his or her consciousness ensures that he or she never stands still, and must embrace the subjective self. While Heidegger (1993) suggests that Dasein is a "projection of possibilities" and represents freedom, Sartre builds upon this by suggesting

that one evolves through a conscious movement beyond the facticity (i.e. the actuality of one's involuntary and imposed circumstances, like cancer diagnosis for my project) after being threatened with annihilation. Sartre agrees with Heidegger that man is thrown into this realm of 'facticity'. What Sartre builds upon Heidegger, is that given sudden crises like cancer, one's life is threatened, compelling the free self to act, by negating this facticity. These philosophical perspectives suggest that the cancer-coping process may not be one of staticity, but one of change, whereby the cancer experience compels one to introspect and fathom one's freedom to transcend one's state of duress and potential death.

In "Being and Nothingness", Sartre analysed man's decision to choose to be unfree or free, to be respectively categorised as the existential concepts of being-in-itself and being-for-itself. Heidegger posits that Dasein is unitary cannot be divided, but Sartre asserts that this can be divided into being-in-itself and being-for-itself (Heidegger 1993:33; Sartre 1956:55). Lastly, he agrees with Heidegger's concept of Dasein encountering its being-unto-death, as realising that one's future possibilities as being destroyed but this compels individuals to act (Sartre 1956:553), as such by negating one's being-in-itself, as seen below. These two concepts expand on Heidegger's being-toward-death, by providing additional existential frameworks to analyse one's reactions to crises.

Being-in-itself is the basis of Sartrean ontology (Sartre 1956). From my own extrapolations of Sartre's existential concepts, for a cancer patient to adopt the perspective of being-in-itself means to (i) perceive oneself as the choiceless outcome of one's external circumstances, such as cancer (Sartre 1956:63), and (ii) to not take responsibility for one's

actions by not meliorating one's conditions through positive cancer-coping (Sartre 1956:59). On the contrary, *being-for-itself* is the transcendence of being-in-itself by "becoming" something more than one's current state (Sartre 1956:138). Heidegger sees anxiety as outside of inner-life and subjectivity (Heidegger 1993:33), but Sartre differs from Heidegger, by suggesting that one uses anxiety to act and negate one's possibility of death and seek transcendence from one's being-in-itself (Sartre 1956:66). Therefore, I apply this to my study, and extrapolate that a cancer patient who embraces a being-for-itself perspective is able to ameliorate his conditions towards growth through meaningful activities.

Additionally, Sartre saw this ability to choose as being represented by being faced by one's *being-in-situation*, or the current moment of a certain scenario, such as the immediate challenge of having just been diagnosed with cancer. Being-in-situation is the contingency of misfortunes in which we face unwillingly and randomly. One who does not embrace her being-in-situation is to flee from adopting the personal responsibility of making meaningful choices in face of the challenge (Sartre 1984), and to give in to defeat (Earnshaw 2006). This is referred by Sartre as being existentially inauthentic. In this, Sartre disagrees with, and builds upon Heidegger, by suggesting that one evolves by transcending being-toward-death (Sartre 1956:277). Doing so leads one to live authentically, whereby the person takes full responsibility for one's challenges.

Therefore, cancer patients who confront their being-toward-death and being-in-situation will confront the challenge of cancer and accept it as an opportunity for growth through transcendence instead of surrender to defeatism.

A SHIFT FROM AN OBJECTIFIED "BEING-IN-ITSELF" TO A PURPOSEFUL "BEING-FOR-ITSELF" PERSPECTIVE

In this section, I shall show how Sartrean and Heideggerian concepts can be applied to growth for cancer patients. Because cancer is a significant life-changing experience for many people, diagnosis can lead to a preoccupation with a being-in-itself perspective of denial (Krumwiede and Krumwiede 2012). Psychological studies often conclude that cancer patients initially cope using ego-defence patterns such as fatalism and dissimulation by believing that there is nothing one can do. The anxiety and depression arising from the nature of the disease (often framed as incurable for Stage IV patients) leads to withdrawal, uncertainty, and lack of control (see Jefferies and Clifford 2012; Šprah and Šoštarič 2004; Halldorsdottir and Hamrin 1996).

Opposite of these were studies which suggest that, over time, many cancer patients were found to shift from a being-in-itself to a being-for-itself attitude. Krumwiede and Krumwiede's (2012:445) finding suggests that at first, cancer patients evinced the confusion of "living in the unknown" by "not having answers [to] a clear direction of which to guide one's life" leading to worry, fear, and anxiety. This is similar to an avoidance of one's Sartrean being-for-itself, followed by subsequent negativity. They then conquered this through appreciating the present, planning for the future, by seeking "trusted connections" with others with cancer to alleviate their fears, and alter their perspective to "live each day to the upmost [and] have a whole different philosophy of life" (Krumwiede and Krumwiede 2012:448). They also found meaning in

community service, family bonding, and interpersonal ties (Blinderman & Cherny 2005; van der Spek et al.2013).

These findings parallel the idea that adopting a Sartrean being-for-itself attitude can lead to their manifestations in meaningful actions. Indeed, these studies present a positive growth-related aspect of cancer. This prompted me in the formulation of my methodology: that perhaps I could operationalise the measure of moving past one's being-in-itself, being-in-situation, and being-onto-death, allowing me to chart a developmental model of cancer-coping.

A SHIFT TO EMBRACING ONE'S "BEING-IN-SITUATION" FROM ENCOUNTERING ONE'S "BEING-TOWARD-DEATH"

Initial cancer diagnosis can lead to a patient in feeling vulnerable and wanting to evade their being-in-situation. In studies of the existential changes of the cancer experience, patients felt initial "intense experiences" (Burke & Sabiston 2012:347) after facing their being-toward-death and observing bodily changes from treatment, which caused many to feel isolated, anxious, fearful, uncertain, vulnerable, anxious and powerless (Hamrin and Halldrsdtti 1996), in line with not having the courage to face one's being-in-situation.

However, many patients eventually moved towards an embracement of one's being-in-situation, which involves boldly confronting cancer, and by making pro-active choices at each moment. As Burke & Sabiston (2012) study found, cancer-surviving participants actively 'outgrew' the anxiety of their disease by mountaineering Mount Kilimanjaro. Studied subjects

felt a shift in priorities and an evolution in life's philosophy arising from awareness of one's death (*being-toward-death*) which instigated them to respond positively through an acceptance of mortality via the valuing of novel experiences, self-knowledge, "looking forward", and in leading a more productive life. This courageous cherishing of each moment is comported by Cordova et al. (2001) and Halstead & Hull (2000), that after surviving, ex-patients had active reconstruction of their experiences through the ongoing re-situation of world values and meaning, spirituality, life appreciation, emotional expressivity, support groups, humor, and by letting go. This continuance of the conquest of cancer at every moment thus signifies an embrace of one's being-in-situation.

Theoretically, I have established the cornerstone in which the urgency of death thrusts people into the spotlight of decision-making and contemplation, in line with Heidegger's concepts. Being presented with death does not necessarily disconnect one from reality - rather, it is this that makes one realise the stark truism of mortality, and from this understanding, life is seen as fragile and precious, and must be utilised wisely. Therefore, within the thousands of messages and interactions within an online cancer support group forum, I may find such social artifacts of some people evincing a poignant concern with the exigency of death, and those who may demonstrate a more philosophical attitude towards this, while possibly seeking to pull the former members from negativity, towards a being-in-situation embrace.

EXISTENTIAL SOCIOLOGY

The prior section applied existential philosophical concepts to provide an analytical framework of cancer-coping growth from negativity to positivity. Existential sociology, however, builds upon this, by emphasizing (i) the centrality of the inner states of human emotions and thoughts in leading to growth, (ii) a more precise mechanic on how internal introspection, arising from crises, leads to growth, and (iii) also how the self is embedded in and grows within interactional contexts. The former section did not expound on how social interactions facilitate growth, instead seeing it as an individual process. While it showed a general process of growth from negative to positive cancer-coping, it neglected the description of the precise inner, introspective states of the patients. This section seeks to fill this void translating Sartrean and Heideggerian terminology into existential sociology.

1) FOCUS OF EXISTENTIAL SOCIOLOGY AND ITS CONNECTION TO HEIDEGGER'S BEING-TOWARD-DEATH

Existential sociology seeks to study human beings in the everyday world which they live in, by examining "many possible [...] complex facets of the human experience" (Fontana 1977:4). This involves paying close attention to elements sometimes ignored in sociology, such as "feelings and emotions" (Fontana 1977:4) and the "subjective, interpretative nature of social reality" (Lyman and Scott 1970). Ultimately, existential sociologists contend that "feelings are the foundation of all thought" (Douglas 1977:14). To study people, one has to focus on existential concepts, such as "freedom, authenticity, sincerity, humanism, empathy, and

creativity" (p. 5). Instead of reducing man to emotionless agents, existential sociology looks at the "complexity of life-as-it-is-lived" (Fontana 1977:6) by examining people's "rational elements to emotion ones, from bodily to mental states" (Manning 1973; Fontana 1977: 9).

Therefore, applying existential sociology to my study, it means that cancer patients' cancer-coping decisions and its influences from other members of the online cancer community cannot merely be reduced to one dimension, such as the individual cognitive weighing of choices in rational-choice theory. Each patient must have their internal feelings and existential states studied. Sartre's and Heidegger's existential categories provide analytic frameworks to analyse and describe such internal states.

How Existential Sociology relates to Being-toward-death

How does existential sociology relate to Heidegger's being-toward-death? As seen in the diagram above, in existential sociology, feelings undergird thoughts, which in turn impact actions. This is neglected in some branches of sociology. Relating to the literature in the previous section (ibid page 15) by Heidegger (1962), Douglas (1977:32) adds that "period[s] of self-crisis", such as from cancer, leads one to confront his being-toward-death, causing powerful feelings, such as the "dread of death", to then trigger feelings of "self-degradation", "severe embarrassment", "anguish", "stigmatisation", and "shame". Such feelings are important, as it triggers growth, since when "lives are disrupted and transformed [...] human feelings dominate thoughts, values, and actions" (Douglas 1977: 32). The cancer experience may lead to the potpourri of crises and emotions described. Summarily, paralleling Heidegger, one's feelings from confronting one's being-toward-death leads to a potpourri of negative emotions, which then leads Dasein to carry out actions which trigger a movement out of it (Douglas 1977). This is the basis of certain cancer-coping growth from being-in-itself to being-for-itself, and the movement towards the embrace of one's being-in-situation. How then, does this lead to growth? The next sub-section explains this.

2) GROWTH OF THE SELF FROM CRISES IN RELATION TO EXISTENTIAL CATEGORIES

In an earlier section delineating the growth from being-in-itself and the avoidance of being-in-situation, to their opposite, there was a void whereby the authors did not cover in their research. Blinderman & Cherny (2005), Krumwiede and Krumwiede (2012), and van der Spek et al. (2013) performed their studies by interviewing the self-described changes within cancer patients who have overcome their crisis, but did not elaborate on the precise introspective

mechanics that led them to evolve from negativity to positivity. Existential sociology allows for the explication of these precise inner processes.

According to existential sociologists, crises trigger growth of the self, through a deeply contemplative process. Douglas (1977:76-124) wrote that crises can "produce the highest self-awareness and self-searching" by causing one to "hit bottom", which becomes a "turning point" for some to reverse the damage. "Physical pain" and "insecurities from identity crises" first compel one to seek a "new life of creation" (p. 82). Johnson and Ferraro (1984: 119) agrees with this, writing that when the existential self faces "taxing circumstances," it will attempt to "incorporate new experiences into its evolving reality". Building upon the "fundamental anxiety" and being-toward-death in the last sub-section, all these findings suggest that crises trigger this anxiety, the dread of death, its accompanying emotional pain, but instead of ending there, it leads to a conscious attempt to transform the self through profound searching and reconstruction.

How is this precise mechanism explained by existential sociology, in the movement from evading one's being-in-situation to its confrontation? After "hitting bottom" through crises, in the above paragraph, one is led into meaninglessness, which makes the individual feel that one is a "victim of external, harmful forces, which destroys the security of the self" - this then compels the self to seek "social forms" to "reconstruct the self" (Kotarba 1984:227) and cope with the threat through "transformations of the self" (Douglas 1984:77). The "intense anxiety, dread, self-awareness [and] ontological insecurity" towards death thus becomes a potent emotion (Douglas 1984:77), which forces the self to seek "redefinitions processes" by finding "source[s] of external definitions", such as from "counselors and other [similar] women" who help them to overcome

their "feelings of guilt and inadequacy" (p. 123) Ultimately, "old meanings are experienced in a different light" such that a "new self" is "replanted, rerooted, and regrounded" (Kotarba 82-125). It also compels the self to "seek new means for self-actualisation" (Kotarba 1984:224). Thus, when faced with one's being-in-situation from crises, one would be led to pain, and pain leads to questioning. Such questioning then leads to redefinition and searching for help from others, which leads to the creation of a post-cancer self based on a being-for-itself positivity, by actively confronting one's being-in-situation than passively submit to it.

How does existential sociology explain the movement from one's being-in-itself to being-for-itself? Existential sociologist, Brown (1977:99), agreeing with Sartre, wrote explicitly, that "consciousness grasps itself as uniquely conscious by negating the in-itself of its own being" (being-in-itself). That is to say, when confronted with crises, a person seeks to grow by realising what she is not (such as in realising from cancer, that one has not fulfilled certain aspirations in life), so that one may grow into it. Existential sociologist, Manning (1973:210), also parallels the Sartrean movement from being-in-itself to being-for-itself, in that one moves from "hope" to "despair". Ultimately, existential sociology builds upon existentialism, by stating that the existential self is "open physically and symbolically to new possibilities", moving forward, and becoming something more (Smith 1984:109). Therefore, the growth towards being-for-itself from being-in-itself is a process governed by expansion through the negation of one's inadequacies, through proactive choices that work towards the actualisation of one's fullest capacity.

How Existential Sociology explains the Movement from being-in-itself to Being-for-itself

Altogether, the synthesis of the first two themes of this chapter are summarised in the diagram above. The first theme shows how crises lead to the profusion of negative emotions and a being-in-itself attitude, while the second theme shows how this leads to an attempt to transcend it proactively through reconstruction, which allows one to grow into one's being-for-itself. Existential sociology thereby builds upon existential philosophy by more precisely delineating the steps between initial crisis and its finality of growth.

3) THE EXISTENTIAL SELF'S INTERACTION WITH THE SOCIAL WORLD

The prior sub-section shows how the self evolves from an individual perspective. But existential sociology suggests that the self is in constant interaction with the broader social world that it is embedded in. It does not evolve alone - but is influenced through interactions with others. Kotarba (1979) emphasized the "focus on the self and its relations to the world" (p. 9-10). The self here is seen as adapting reflexively to the social world around it (Fontana 1977:11). Building upon Mead (1934), Lester (1984:28-55) argues that the existential self is an "ongoing process" that changes each time it "takes the attitude of others", by in turn reacting to it, to "seek to find meaning in his transactions with the reality" of the social world. Patrick & Bignall (1984:207) wrote that daily life is a "dialectical confrontation between the self-I-think-I-am and the self-they-think-I-am" (Patrick & Bignall 1984:207), where one's daily life, "self-feelings and self-other definitions [and] expectations]" are influenced by others, through "organisational and interpersonal procedures" (Altheide 1984:177), leading to "self-development [that] involves [...] discovering who I am to relevant others (role) and who I am to myself (self)" (Ebaugh 1984:156). For instance, disabled individuals may feel tension if their prior self-image is not "congruent with the identity [he] wishes to be known" (Patrick & Bignall 1984:208). This behooves them to mix with a "fraternity of the like-minded", forging "the same goals and using the same tools and analytic concepts" (p. 214). Altogether, the existential self's growth through crisis is impacted by its embedment within a broader social reality - simply put, the self does not exist alone.

How do people, such as cancer patients, capitalise upon society to grow? Kotarba (1984: 225) wrote that humans "constantly attempt to shape and manipulate society" and "have it as a resource for fulfilling [one's] basic needs and desires. For instance, it may involve seeking counsel from others, or providing guidance to them. This is exacted through the formation of "social roles" that are "created to meet the needs that emerge" as the self confronts itself and the social world (Kotarba 1984:226), such as a new cancer-coping self that arise to seek growth by seeking help from similar others. The existential self, evinced in its "feelings, perceptions, [and] decisions" in turn become "determinants of organisational life" (Kotarba 1984:228). This means that the person in crisis seeks help from others to reconstruct his/her new self, which then contributes to the broader community by seeking to help others transform as well.

Is there a progressive model of growth in the existential self's interaction with society? Ebaugh (1984:160) suggests that this process occurs in stages. The first stage involves "initial questioning". The second involves interacting with those who challenge or support their current conceptualisations, leading to "questioning and shaking of [their] foundations" (p. 163). This involves "questioning taken-for-granted [...] systems through social contacts of options" (p. 165), such as by "formulating new forms of order to deal with" such "new, ambiguous and conflicting situations" (Smith 1984:115). In the third stage, one decides to try out the "options of a new life" by "re-establishing oneself in a new identity" (Ebaugh 1984:166). During the final stage, one has a newly-constructed self that comes from "harmonising [one's] self-definition and role expectations" (p. 168-169). As I shall explain later using social constructivism (ibid page 30), I shall hypothesize a four-stage model of growth. The bottom diagram summarises this dialectical process between society and the existential self, covered in this sub-section's theme:

Interaction between Self and Society

Existential sociology thus attempts to describe the evolution through the existential categories (i.e. from being-in-itself to being-for-itself etc.) beyond a mostly psychological, existential and individual point of view, in showing how interpersonal relationships enable these cancer-coping beliefs to occur. In the below paragraphs, I examine how a sociological developmental model of cancer-coping can be constructed.

Existential sociologists borrow heavily from Berger and Luckmann's social constructivism, and therefore, I feel it is appropriate to bring their model here to elaborate on this social dialectical process between self and society. Berger's and Luckmann's (1966) "Social Construction of Reality" suggests that the basis of everyday reality involves interactions that classify people or objects based on typificatory categories such as "Europeans" (p. 45). This "continuum of typifications" contributes to a shared "stock" of sociocultural knowledge which is mediated through daily face-to-face interactions, spoken, or written language, that allows people to understand the social reality of everyday life (p. 47-48). Human activity produces uniform patterns through habitualization, which continuously performs actions repetitively, such that when it is objectivated, the subjectivity of its "meanings involved become embedded as routines in his general stock of knowledge", which can be extracted for future projects and purposes (p. 71). When there is a "reciprocal typifications of habitualised actions by types of actors" such as breast cancer patients, individuals are able to obtain uniform typificatory categories to act on the basis of regularity, which leads to institutionalisation at a societal level (p. 72). This objectivation and habitualisation is done through signs with shared intended meanings, such as symbols, language, or material artifacts, which embody human subjectivity and objectivate them into the surrounding world, and further reinforces and adds to the social stock of knowledge. The "continuing social situations" in institutions in turn reinforce the reciprocity of acts, which leads to control over human conduct and actions. Through a concatenation of various institutions, a social reality of objectised meanings will be constructed.

How does this interplay with existential philosophical concepts, and of existential sociology? First of all, cancer patients, upon confronting their being-unto-death and being-in-

situation, may then be influenced by other social agents with regards to how to make sense of such. Upon cancer diagnosis, patients may exhibit dread and hopelessness towards the situation. However, when immersed with an online cancer forum, they come into interaction with others. Douglas (1977: 19) wrote that "man is thrown into his social world at birth and can live only by being part of [...] society," such that certain forms of "social patternings and agreements" pre-exist in that society. These "social patternings" parallel Berger and Luckmann's (1966) "typifications" and "stocks of knowledge" and provide "rules made for living" (Douglas 1977: 20), prescribing order and procedures to deal with social situations. Cancer support groups may provide such social prescriptions involving procedures for positive cancer-coping to newly diagnosed patients, socialising them into positivity, instead transforming their Sartrean being-in-itself disposition to one of being-for-itself, and their dread of their Heideggerian being-unto-death into courage towards life. These cancer-coping stocks of knowledge also facilitate communication and intersubjective understanding", allowing for "shared experience for the commonsense understanding that underlie all social order" (Altheide 1977:140), whereby the self cooperates with others of "similar concerns" to sustain this "social forms created by others" and maintain the Berger's stocks of knowledge (Kotarba 1984:228-229). With respect to a cancer forum, such stocks of knowledge may be generalised collective beliefs and assumptions that one should maintain a growth-oriented atmosphere on the forum. Breaching this stock of knowledge may render disapproval from other users, as it creates a pessimistic mindset that may prove detrimental to these users.

Thus, stocks of knowledge provide (i) procedures and (ii) shared understanding, that allow people to act and live within a social organisation. For cancer patients entering an online

social support group, senior and experienced members may provide various cancer-coping "stocks of knowledge" through the habitualisation and objectivation of their inner subjectivities, which allows new members to make sense of "social patterns" to cope with their crisis, and subsequently face their being-unto-death and being-in-situation, while also allowing them to communicate with other cancer patients without fear of offending each other. When sufficient users maintain a desire for positivity and optimism at most times, they may refute the negativity and pessimism of other users. When this number is a majority, this inner mindset may be objectivated to the forum, which becomes created and sustained as an accepted stock of knowledge. When the "holders" of this stock knowledge, such as senior members who have overcome and survived cancer, use means such as counselling, words of wisdom, help, empathy, and support to other users, they may counteract the presence of a diametrically opposed negativity by new users who have recently been diagnosed with cancer. Therefore, one purpose of this study is to chart these discernible stocks of knowledge that are being upheld, regulated, and sustained on the cancer forum.

Does this mean that cancer patients are necessarily always shaped by such stocks of knowledge with no room for agency? As Berger & Luckmann (1966) wrote: "Society is a human product. Society is an objective reality. Man is a social product" (p. 79). Human subjectivity is externalised to society through the assistance of language, "transmitted to the next generation [...] learnt as objective truth in the course of socialisation and thus internalised as subjective truth" which in turns contributes to the institutionalisation of sufficient stocks of knowledge which serve as objective descriptions of reality (p. 84). The "personal characteristics, mannerisms [and]

idiosyncracies" of individual members also permeate the organisation (Smith 1984:115). This seems to depict limited volition within social agents.

On the contrary, Douglas (1977: 61) wrote "experience, internal response, and action are necessarily partially contingent and free", suggesting that there exists some degree of free will or negotiation between, for my project's case, newly-diagnosed patients and experienced ones, to influence the manner in which the former make sense of their inner feelings. Other existential sociologists also aver to this: I repeat Smith (1984:115), who wrote that the self is "open physically to [...] a congeries of unfolding, open possibilities". The self is "sentient" for existential sociologists (Manning 1973: 212), as there is a continuum of "independence and dominance over social rules" (Lester 1984:58). This means that the self may choose to accept these "stocks of knowledge" or reject and/or re-negotiate them.

The resolution of this paradox may lie in a combination of both agency and structure, as Altheide (1984:177) wrote, that the self is both shaped by, and also shapes, the organisation it is embedded in. Applying Berger and Luckmann (1966), it is possible that internalisation leads to externalisation and institutionalisation, which then leads back to internalisation, such that individuals impart their own subjectivities into the social organisation, which then shape future agents. Summarily, both agency and structure therefore contribute to the production of the "stocks of knowledge" in a group, and that such stocks are also malleable and ever-evolving. Therefore, for my project, cancer patients in the forum may choose to abide by, or refute the forum's cancer-coping "stocks of knowledge" - rather than being non-agential, they are volitional

beings that contribute to these stocks, shaping them, and are also sculpted by them. They also sustain the stocks of knowledge by infusing their self to the organisation.

The Cancer self is a confluence of individual reflection and societal influences

In synopsis, the above diagram synthesizes the ideas of existential philosophy and existential sociology in theme three of this chapter. It shows that that cancer self's growth through the existential categories of being-in-itself and being-in-situation is a confluence of both individual reflection and societal influences.

EXTRAPOLATIONS FROM THE LITERATURE REVIEW

My first research question is on whether some studied cancer patients may follow a developmental pathway from negativity to positivity during their time on the forum. Based on the literature, I extrapolate that many newly-diagnosed cancer patients will enter such online cancer support groups to post to seek consolation, information, support, and encouragement. In the process of doing so, they may externalise their initial negative existential perspectives which are based on (i) an evasion of one's being-in-situation, and (ii) maintaining a being-in-itself mentality. This will lead to much dread, anxiety, and negative emotions, which compels them to seek help from others. This may be followed by a desire for development towards a new positive cancer-coping, post-cancer self.

My second research question asks what are the exact social processes through which people's cancer-coping beliefs and practices are transformed via social interactions with more experienced forum members. From a social constructivist and existential sociological viewpoint, the newer patients will be socialised into internalising the ideals of more experienced ones. Experienced members may re-define and re-situate newly-diagnosed members' negative cancer-coping attitudes until positive ones have been internalised in new members. This is done through the significations of encouragement, mutual provisions, aid, advice, sharing, joking, and less serious conversations. This ongoing dialogue between the self and society will lead to much introspection, before these members discard their original negative cancer-coping views. This process of contestation of beliefs on the forum can be sociologically investigated to formulate a theoretic-developmental model of cancer-coping.

Finally, my third research question asks how patients move away from their initial "life crisis" and then transmit their knowledge to others. I suspect that there are several "stocks" of collective and generalised beliefs associated with cancer-coping which are prevalent, or perhaps even predominant on the forum. These generalised beliefs, I surmise, may be sustained and upheld by certain "gatekeepers" who may refute non-growth-oriented memes from cascading uncontrollably, which are deleterious to the spiritual well-being of patients.

Therefore, my proposed model seeks to synergise both existential precepts using that of Heidegger's and Sartre's analytic frameworks, with that of an existential sociological approach that suggests that cancer-coping in cancer patients is greatly facilitated through a process of social influence, which raises their awareness towards a more growth-oriented cancer-coping perspective. The process involves the learning of the prevalent norms of several dominant "stocks of knowledge" that foster growth vis-a-vis resignation, with experienced patients serving as intermediaries and guides. Ultimately, the self is not separated from society, and its growth is affected through it, and it also shapes others in the process. This proposed model is visually presented in figure 1 in Appendix B.

Methodology

Chapter 3

The methodology of the project involves internet research, which encompasses the use of unobtrusive qualitative content analysis to parse the posts on the online cancer support group studied. I performed both inductive and deductive coding after observing and immersing myself unobtrusively in the selected forum.

INTERNET RESEARCH

Many unobtrusive internal research methods have been developed in the last twenty years. Established literature in this field (Jones 1999; Mann & Steward 2000) agreed that the internet is a data-gathering instrument for qualitative research. Golder et al. (2007) used data from the header messages of exchanging Facebook users to study the work routines of students. Webb et al. (1981) used the log files of website activity to find out what people are interested in on the internet. Lastly, Lee (2000) used data from forums to study the exchanged interactions' comments using search engines. Their common denominator is that they all include online data (Varis 2014).

Hine (2011) suggests that the advantage of such internet research methods is that it is less labour intensive for the researcher. Another advantage of this method is that it provides researchers with unparalleled informational access to studying people's lives online (Georgakopoulo 2013; Rymes 2012; Varis & Wang 2011). However, a disadvantage is that it provides only a partial view of the world (Geertz 1973; Lee 2000). Also, search engines on

websites or forums do not index the entire internet and may therefore skew researchers in certain narrow dimensions (Wouters and Gerbec 2003).

SAMPLE PROCEDURES

I performed purposive quota sampling on the individual posts of cancer patients on an online internet cancer support group discussion forum. I sampled and analysed around 800 individual posts.

The sampling frame was mostly threads that focused on four things: first, a large number of threads analysed were from a cancer sub-forum for breast cancer of various stages (from stage I to IV), but with a focus on stages III and IV. Second, to contrast the dynamic interaction between experienced cancer-experiencers versus newly-diagnosed individuals, threads were chosen to emphasize this dialogue between the two, but also of those between any two individuals, regardless of experience. Third, the threads focused largely on the inner emotional and existential processes of the individuals, raising problems such as one's connection to life and reality, instead of the technical aspects of treatment, diagnosis and prognosis. Fourthly, many of the threads chosen were very long (upwards of more than 30 - 50 replies), so as to allow me to capture the temporal processes of the existential inquiries within and between the patients. Next, the posts within the threads were mostly chosen, with a deliberate choice of those with a long-term dynamic extending for several weeks or months in order to study the historical processes of existential change in individuals and its impact from social interactions.

The target group involved an internet study of people who (i) had cancer at the time in which they posted, interacted, or sought help, or (ii) those who had cancer but have been cured at the time of posting. As for the first category, it may refer to cancer patients who (1) have just been diagnosed with cancer at the time of posting and were unsure of their prospectus, and (2) on-going patients who have overcome the existential anxiety, fears, and tribulations of cancer towards a growth-oriented life perspective. This second group may either have been cured, have ongoing cancer, or have had numerous recurrences of cancer even till the moment of posting.

The individual posts of cancer patients on an online cancer support group forum formed the level of analysis.

The samples were obtained using non-participatory and non-invasive data gathering, as I did not write any posts on the studied forum, nor were any cancer patients interviewed directly. Only their posts and threads were studied. This was due to ethical grounds (ibid page 46) that may not get past the school's IRB approval.

DEMOGRAPHICS OF THE SAMPLE

There was no explicit data available on the actual demographics of the users on the forum. Research on the demographics poses several problems, as firstly, many users left their profile pages completely blank. Therefore, I have sampled only those where their profile pages have been written with meaningful information. The number sampled is 50.

Additionally, it was not a standard practice for users to explicitly indicate their ethnicity. There was no direct way of inferring the user's ethnic group, other than from photos that they have loaded. Therefore, there is no accurate quantitative way of assessing their actual racial profile, though 28 out of the 50 sampled had some information on their ethnicity, such as photos. From these, 25 (89.2%) seem to be Caucasian-whites, with 2 (7.1%) being Black. Of the former, it is not known to which degree some of them may be Hispanics. There was only one Asian among the sample (3.6%).

It was not possible to infer their religious demographics scientifically using any samples, although from their language, evinced in phrases such as "god will be with us", and occasional citations from the bible, a large proportion of them may be Christians. The exact percentages cannot be inferred. I have yet to encounter any individuals who quoted aphorisms from Buddhism, Taoism, Confucianism, Hinduism, or Islam.

As for gender, since breast cancer is mostly an affliction affecting females, I did not see any male posters. Of the sampled profiles with traceable information, all of them are female.

The age was more easily inferable. However, of the 50 samples, only 42 indicated their age explicitly. Those who did indicated the dates of their birth, thus it was easy to calculate their ages. Due to the paucity of data, exact statistical percentages cannot be derived, however, there were 29 who were above 50 years of age, which is understandable, since breast cancer has a positive correlation with age. None among the sampled population were below 35 years of age. 13 fell between 35 to 49 years of age.

Some of the patients did indicate their profession. Again, only 18 individuals indicated such. Many were teachers at the primary to tertiary levels, researchers, executives, writers, or had other 'white-collar' jobs (9). I did not see many individuals engaged in more 'masculine' professions such as engineering, architecture, or medicine, though one of them was a nurse. 5 had blue-collar or working-class jobs such as salonists, receptionists, or clerks. A significant percentage were unemployed (4). It is not known if the former two continued in their career.

For nationality, most of them were from the United States (20 out of 32). There were occasionally those from Canada, and English-speaking countries of Europe, such as Great Britain, for the remaining 12.

STEPS OF THE DATA COLLECTION AND ANALYSIS PROCEDURE

This project combined the content analysis approaches of Fereday and Muir-Cochrane (2008) and Braun and Clarke (2006) to utilise both inductive and deductive categorization to study the social interactions of the cancer patients, and their existential states.

Content analysis is a search for themes central to describing events through the identification of such using "careful reading and re-reading of the data" (Rice and Ezzy 1999:258). Braun and Clarke (2006) detailed several steps to content analysis. They maintained that there is no correct way to proceed with interpretation of data, and that it is also non-linear but reiterative, involving a cycle of re-interpretation that develops as a process (Ely et al. 1997).

The steps of the data collection and data analysis were as follows:

1) Data Familiarisation

Braun and Clarke (2006) maintained that data familiarisation involves "immersing" oneself in it through repeated and active reading of data to understand its underlying rich meanings. To achieve this, I have re-read the studied forum for three weeks before gathering data. Another month was spent on re-reading the data obtained. I also spent time searching using the forum search engine, the histories, past threads and posts of the studied subjects in order to familiarise myself with their background and circumstances.

2) Codebook Development

Using Boyatzis' (1998) methodology on codebook development, I first wrote codes with their (i) code name, (ii) corresponding code definition, and (iii) their operationalisation or means of detection. A "codebook" refers to a template of pre-existing codes theoretically formed prior to the analysis to organise data (Crabtree and Miller 1999:3-4).

Braun & Clarke (2006) instructed that as many fundamental categories of data should first be created in order to encapsulate more content. A good "code" is one that encompasses the qualitative detail of the phenomenon (Crabtree and Miller 1999:3-4). According to Boyatzis (1998), this involves a study of the existing literature to deduce themes which might be present

based on the predictions of existing theoretical paradigms. The codes that I have operationalised are explained later below.

Boyatzis (1998) mentioned that the code must be explored to ensure its practicality. To ensure this, I have conducted test of the operationalisable codes to test their validity prior to finalising the deductive codes for the actual study.

3) Application of Codebook and Extra Coding

I then applied the cookbook to analyse data, and created additional codes if current operationalised deductive codes from the literature review were insufficient to account for new themes using Boyatzis' (1998) inductive approach. Thus both deductive and inductive methods were used.

4) Data Summarization and Initial Theme Identification

I did this through the reading, re-reading, and summarization of raw data through one's "own paraphrasing" (Boyatzis 1998:45).

5) Theme Searching and Connecting

Braun & Clarke (2006) instructed that this involves the collation of all data into elementary codes, followed by a review to extract their underlying similarities to identify

encompassing themes. An example of this is the classifying of subthemes such as *being-in-situation*, and *being-for-itself* under the larger theme of cancer-coping predicates. Next, theme connection involves relating each theme to each other (Crabtree and Miller 1999), such as how social interactions facilitate cancer-coping attitudinal changes in this project.

I reviewed the themes again to collapse some together, to eschew some which were redundant, and so see how each fitted into my theoretical perspective (Braun and Clarke 2006). While researching, I also found many inductive themes that did not fit the deductive categories, but were ample and important enough to be reported in this study.

6) Organizing Themes and Confirmation

This involves clustering available themes and confirming the validity of the themes by "re-iterating" the entire process to see if themes match the data (Crabtree and Miller 1999:170).

Operationalisation

Some of the deductive codes that I have employed in the abovementioned clauses (2) to (2b) have been operationalised in the following organisation. Actual examples from the codebook that I have compiled are shown in tables 1 to 3 in Appendix A:

Original Thread Title		
<i>Thread message</i>		
A makes the remarks below B approves or disapproves to the right	<i>Signs of Explicit or Implicit</i> Approval or Agreement	<i>Signs of Explicit or Implicit</i> Disapproval or Disagreement
1a) Stagnation in a <i>being-in-itself</i> orientation	A states X. B replies to A, saying Y. C replies to B, saying Z. D replies to C etc.	
1b) Shift to a <i>being-for-itself</i> orientation		

Clauses 1a and 1b were then replaced with other existential categories, as shown in examples 1 to 3 in Appendix A. The vertical axes of the 2x2 charts represents forum posts by cancer patients (A) with the characteristics from (1a) to (4b), while the horizontal axes denote the replies of other patients (B) towards (A). I filled each cell in with the actual quotes of the posts from the forum, and is formatted flexibly such that replies by other patients (C) to (B) can be transcribed onto them with relevant field notes and comments. This allows for a continuous succession of interactions to be charted, and their dynamics explored fluidly. An example of this is illustrated in table 3 of Appendix A.

Ethical Considerations

Rodham & Gavin's (2006) investigation of internet research ethics suggests that online research has fewer agreements on well-defined guidelines. They nevertheless maintained that for research involving message boards such as online public cancer support group forums, no informed consent is required for forum users are aware that they are posting in public domain. Nevertheless, the Association of Internet Researchers (AoIR) suggested that in internet research, anonymity and confidentiality should be ensured through the pseudonymisation or paraphrasing of extracts, people, or the website, due to the traceability of one's identity using search engines.

Buchanan (2012) of the AoIR also mentioned that unobtrusive methods like online forum studies are less concerned with control due to their non-involvement; however some internet spaces may be private (like restricted forums that require a login account to view texts), which may lead to widespread sharing of unauthorized data. This therefore requires special ethical attention to their confidentiality and privacy. However, the forum that I will be investigating is public.

Therefore, the following ethical steps have been taken for this project: first, where direct quotes were illustrated, the subjects' names were replaced by pseudonyms. Second, it has been discerned that the studied website is public and thereby requires no informed consent. Third, no interviews with the cancer patients shall be made. Additionally, the study is non-participatory and I will not post any messages or posts on the website. Fourth, while it was not possible to remove all identifiers, such as the use of direct quotations from the website, additional steps shall be taken to conceal the name of the online cancer support group, by not directly naming the threads.

The Realisation Stage

Chapter 4

"lone, alone, alone, always. I have not been this sad since my son died twenty years ago. I am sure this makes no sense, all rambling, no sense I just don't know if I can do this alone! Help!" -

Dorothy

INITIAL AND ONGOING REALISATION OF CANCER

In existential sociology, the self is "an active agent in the process of change" (Kotarba 1984:229). Berger and Luckmann (1966) posit that this individual, agential consciousness is the provenance of all social reality. Its initial tryst with cancer thereby leads to a state of realisation - of profound upheaval and reflection on how life has been disrupted. I define realisation to be that of the initial and ongoing feelings of anxiety, dread, and fear, coupled by its cognitive components of the necessity to confront the exigency of one's possibility of death (being-toward-death), which follows after cancer diagnosis. Oftentimes, since the dominant discourse surrounding cancer involves negativity, the person thus comes to attribute mainly negative meanings to the diagnosis. Realisation therefore entails that when a person is diagnosed, she attaches such negative preconceptions and meanings from the broader culture to the diagnosis in a being-in-itself or pessimistic manner. This period of time can be immediate and prolonged, involving the confrontation of one's being-in-itself and being-in-situation.

Initial Realisation of One's Being-toward-death and Being-in-itself mentality

As mentioned in the literature review, existential sociologist, Douglas (1984) suggested that one basic existential drive within us is the "fundamental anxiety" (Schutz 1962:227), arising from "meaninglessness, isolation, shame, and ultimately death". Emotions, such as the "fundamental anxiety" towards one's being-toward-death, steer human action (Clark 2002:163), inciting people to seek help from others to "overcome [this] obstacle" (Schutz 1962:228). This is realised by the following quote by Paige, in a thread on September 2015, involving the sudden realisation of cancer, immediately after diagnosis with grade 3 DCIS breast cancer.

"[...] I cannot stop crying every since dx. Why am I feeling so afraid? [...] Why I am feeling so sad? It is the feeling that everything that I have worked for in life are coming to end. I just cannot get pass the feeling that I am going to die next. i cannot get over this. please help!!!!!!!"

Seen here, a very dramatic catalyst (Johnson and Ferraro 1984), being breast cancer, compelled Paige to seek help on the forum. Paige's inability to "get pass the feeling" and to "get over" her "going to die next" suggests an apprehensive realisation of her being-toward-death. This "fundamental anxiety" towards death was followed by expressed feelings of a lack of volition or power, shown in how she "cannot get over this" to overwrite her current predicament, during the realisation phase. However, by entering the forums to seek help and understand one's conditions, such as Paige's feelings of being afraid to die, it suggests a concerted effort to overcome the initial quagmire. I followed Paige to another thread on feelings involving cancer

being a death sentence, in October of that year, which is the main analysed thread in this subsection:

"So here I am pretty sure I'm gonna be dead in ten years at the ripe old age of 50. I can't decide if I want to cuddle with my three year old and sniff his hair all night and hope he doesn't elbow me in the chest or get a 12pack of Miller lite and drink till it's funny or I pass out (or both). "

Kotarba (1984) wrote that when an individual faces an uncertainty that may encroach on one's existence (being-toward-death), it may lead to two outcomes: first, either the individual is dislodged from one's comfort grooves and does nothing, or second, the individual attempts to perceive new possibilities to return to normality and equilibrium by adapting to the circumstances. Paige's insinuation that she was unable to decide, while adhering to a retreatist way of coping through drinking over taking care of her child before her potential demise suggests the former: a relegation of her destiny to external forces beyond one's individual control upon encountering being-toward-death. This establishes herself as an avolitional being-in-itself. Additionally, she adds:

"I think I've pin pointed my problems to the utter lack of control. The fact that that we take our best knowledge, and plans, and will, and just throw it to the wind and see what happens is the part that bothers me most [...] Sadly, there are no guarantees in life."

In saying that one's outcome is determined by the "winds" of fate, she further surrendered her capacity to improve her lot to the treads of fatalism. This agrees with an existential sociological study of victimisation from painful external circumstances, where victims made use of rationalizations to deny injuries dealt to them, by acting and behaving fatalistically, similar to Paige's response (Johnson and Ferraro 1984:119). This self-proclaimed avolitional "lack of control" entails a being-in-itself attitude. Additionally, in saying that "there are no guarantees in life", and in acknowledging her lack of control, it shows that the realisation stage is where individuals come to terms with the stark reality and harshness of cancer - that it is an involuntary and unfair calamity that suddenly intrudes and disrupts one's life.

Do these internal feelings of negativity become objectivated (see pages 30 and 61 for the definition of 'objectivation') in some degree to external reality, rather than just being in the mind? Here I cite Dinna, who replied to Paige and wrote of her experiences following her immediate diagnosis in the past within the same thread. Dinna was having stage 2 breast cancer as of writing the message:

"[After diagnosis] I didn't want to [...] eat anything or drink anything [...] I just could not imagine living every day of my life like that. I figured that I had been given a second chance at life and I didn't want to spend the rest of it twisting myself up in knots about the maybes [...] it took me a good two year's post cancer to reach a truly peaceful place for myself [after which] I still drink wine. I still enjoy pasta and smoked salmon. I still celebrate my birthday with a slice of triple-chocolate cake with chocolate chunks [...]"

Here, the first half of the quote shows Dinna explaining her initial negativity upon cancer diagnosis 2 years before writing this message. She describes losing the enthusiasm to eat or drink, while also “twisting [her]self up” in “maybes” (uncertainties). By saying she “didn’t want to spend the rest of [her initial two years]” doing such, this shows a *protracted* effusion of the aforesaid uncertainties and discomfort into her life for 2 years. This in effect shows that, beyond the fatalism and ennui faced by Paige from earlier, which seem to be merely attitudes within the mind, there is now a permeation of both one’s internal and mental states of uncertainty and a lack of enthusiasm, *into* one’s life that parallels a being-in-itself mentality that does not seek to fully embrace living. In contrast, the second part of the quote shows how she has evolved after 2 years to a “peaceful place” where she now enjoys dining on good food and celebrating her birthday, which are indications of having evolved towards exuding both verve and embrace towards the enjoyment of life, which typifies a being-for-itself attitude. Therefore, paralleling the postulates of existential sociology (Kotarba 1984:227; Douglas 1984:69; Johnson and Ferraro 1984:119), many social actions follow one’s intense anxiety towards possible death, as shown in Paige, which is objectivated to the forums (Paige's case) and one’s life through initial uncertainty, ennui, and pessimism, as shown in Dinna 2 years ago.

Somewhere in between the 2 stages; however, something must have happened to motivate Dinna out of her initial ambivalence and ennui. I gathered more evidence to substantiate how she could have evolved out of this, in another of Dinna's subsequent reply to Paige:

"Cancer- and cancer treatment sucks, but you can get through it and move forward.

Allow yourself to grieve and feel angry; these are perfectly valid responses to what is

happening to you. I, personally, found anger to be a great motivator. It pushed me to hang in there and keep going when all I wanted to do was stop. Use your fear and anger to keep you strong."

Because Dinna mentioned that anger and grieving are "valid responses" in the experience of cancer, it suggests that the realisation phase ends not in contemplation - it is further manifested in physical reality through the effervescence of such negative emotions like anger, and a subsequent social behaviour of using anger as a "motivator" to "keep [one] strong" and "keep going". The latter implies that rather than ending in negativity, cancer, as a crisis, may compel one to eventually proactively seek attenuation and amelioration of one's circumstance. Below is a summary of Alise's interaction with other forum members:

Interactions within the thread

To summarise, cancer diagnosis initially leads one to confronting being-toward-death, which calls forth the "fundamental anxiety", and the dread of dying. This leads to much uncertainty, lack of control, and pessimism, which are then objectivated on the online cancer forum, and in their personal lives, via a being-in-itself attitude (in Paige's and Dinna's initial case). This then leads to much questioning in the realisation phase, on how to cope, followed by a desire to seek help from others, and the staunch realisation of the powerlessness of the cancer self in face of possible annihilation, like in Paige's case. Nevertheless, Dinna suggested that this does not end here; rather, the fears and anger from cancer may ironically motivate one start to realise that growth during cancer is possible.

Initial and Ongoing Manifestation of Negative Emotions and Uneasiness towards one's Being-in-situation

Some patients expressed initial sadness and negative emotions at their predicament shortly after diagnosis, trying to decipher the consequences of cancer intruding upon their lives unexpectedly with "no insurance" (see below). In a sub-forum for the recently diagnosed, Crystal vented these feelings on Sep 2012, following her diagnosis on 31 Aug 2012 with stage IIA IDC. This thread involved feeling lost.

"Why me? I have no insurance, and wonder to myself what exactly is the price on my life. I have so many emotions running through me, and the thoughts are unexplainable at times. Am I crying too much? How can I be positive when I feel so alone? Im new to cancer, and this site. Please someone, tell me whats next?"

The evincement of negative emotions, such as from "crying" and not feeling "positive", suggests that Crystal, as of this point, has not yet cultivated the temerity or elan required to bravely engage her being-in-situation. While some members projected a plethora of negative emotions towards lives at the involuntaristic nature of their situation, others expressed confusion, self-blame, shame, and uncertainty at their situation, as Jessica wrote in same sub-forum on April 2013 shortly after diagnosis, replying to Crystal:

"At a time when I thought of expressing my feelings the most, Ive found myself at a loss for words. Some how "Ive caused this", "its all my fault". Im sure these are all normal emotions, but I cant find the words, I feel ashamed/embarassed."

Rather than showing both acceptance, fortitude and self-forgiveness required to face one's being-in-situation, self-blame and self-victimisation were showed, in the realisation stage, in Jessica's example above. This parallels an existential sociological study by Rose (1984), who found that confrontational experiences/crises with sudden changes from one's comfort grooves, led to negative feelings, self-blame, and a shaking of one's prior-assumed stability in life (Rose 1984). Being overwhelmed by a predominance of negative emotions thus characterises the initial stage, in a manner that seems to inhibit growth and positive coping.

Another person, Vermillion, who is still having ongoing stage 2 breast cancer, responded to Jessica:

"We've ALL had your emotions at one time or another, and I think that the waiting, the unknowns, the questions, the out of control feeling is maybe one of the hardest things we are handling. Our minds can go EVERYWHERE when we lose some controls"

The above message, unlike the previous ones, which involved mainly introspection, now involves the translation of one's inner state of "los[ing] some controls" in one's lives into physical actions within reality itself, through "waiting, unknowns, the questions", and the subsequent losing of one's mind "everywhere". Manifesting an embrace of one's being-in-

situation involves taking charge of one's immediate occupations in a courageous manner; the lack of taking control to deal with one's life, shown above, parallels the opposite.

To substantiate this further, I followed some of the members on the studied thread to another topic by checking their profile history. In a thread on wanting to feel blessed and move on, Eleanor wrote:

"I would agree that I'm not the same person as I used to be. I was a very confident person before I was diagnosed and lost that during treatment."

Additionally, Venus wrote:

"I am feeling so foolish and weak because I finished all treatment in November 2010. Here it is almost two years later and I am still go over and over it. I can't seem to let it go. It's like I have PTSS. Every night as I am "trying" to go to sleep I think about getting BC again. Certainly I am worried about getting it again but I think I am feeling a void without it."

On tracing and studying the histories of Eleanor and Venus, both of them seem to be in the realisation phase - there was a paucity of evidence from their messages on other threads at around the time of posting, that they described having progressed beyond "let[-ing] go", "feeling a void", and "think[-ing] about getting BC [...] over and over". The fact that Venus described this protracted process of "weak[-ness]" and continued worry for 2 years, and that Eleanor mentioned

that she had lost her confidence and was no longer the "same person" she used to be, there is evidence to suggest that there is a discernible or observable manifestation of breast cancer's impacts on their psyches, which is then effused into real life through constant worries and diffidence. This entails a lack of resolve or endurance to accept and overcome their preoccupation with the threat of cancer, by displacing it with mettle and eagerness to face life's vicissitudes.

Can one progress beyond the realisation phase? In continuation of the former thread by Crystal and Jessica, to assuage Jessica's pain, Joannis responded to her:

"I truly felt a sense of relief when I finally sat down and had my questions answered. One day when I was down and talked about having cancer [with her husband] What a challenge for us, and we're choosing to take on this challenge. My friend is running a marathon at the end of the month, and she encouraged me with....."We're both doing marathons". I started it, and, trust me, there will be moments of walking slower, but every step puts us at a FINISH line. We can all say to take it one day at a time (easy words) but we really do take it one day at a time.

While the prior posts depict the initial experience of cancer as being highly negative, the above quote suggests that a desire for growth may follow from such. In here, the decision to finally talk about cancer with her husband after "having finally sat down" and having "started it" demarcates having hit rock-bottom, followed by a realisation that cancer is not necessarily an end, and that one can begin to make slow improvements, such as through marathons. This lends

support to the notion that the realisation phase's agonising tribulation may be followed by recovery for some people, paralleling Kotarba (1984:82) and Johnson Ferraro (1984:119) that "taxing circumstances", and "crises" leads to subsequent, attempted amelioration of one's life. This recovery, in my study, is not strictly endogenous, and can be facilitated through the encouragements of others, as seen in the next chapter. I summarise the interactions in the thread with the following diagram, showing how Crystal's initial negativities were commiserated by Jessica, Vermillion, and Joannis:

Interactions within the thread

THE REALISATION STAGE: A SYNTHESIS

Seen in the chart above, my evidence complies with existential sociologist, Clark's (2002:155) findings, that emotions underlie many of the subjective human experience and its social world on the forum, in line with the first theme of existential sociology covered in my literature review (ibid page 21). Cancer diagnosis causes one to "hit rock-bottom" and feel completely helpless, as shown in Joannis's post. Then, seen in the case of Paige, this conjures a powerful emotion: the "fundamental anxiety" (Schutz 1962:227) towards death, which thrusts the existential self into confronting its being-in-itself. This leads to the realisation of the powerlessness of the cancer self, leading some to manifest initial fear, negative emotions, avoid

their being-in-situation, and see one as a choiceless being-for-itself construct, which are then objectivated on the forum, as seen in the remarks of Paige's, Jessica's, Crystal's, and Vermillion's evincement of fear and dread following diagnosis. As in Dinna's case, one's ambivalence and ennui are objectivated into one's own life as well.

The existential self, when threatened with such challenging situations, will then struggle to integrate the new experiences into its evolution through intense questioning and contemplation, as shown by Jessica and Crystal. This leads to a possible turning point that may lead to subsequent attempted ameliorations of one's life (Johnson and Ferraro 1984) through the seeking of help, like in Paige's and Crystal's case, or the beginnings of the realisation that one may convert one's negative emotions, like anger, as motivation for positive change, in Dinna's and Joannis' cases. This process shall be covered much more thoroughly in the next chapter.

This chapter relates to the second research question, in that it suggests that in the realisation stage, new, inexperienced cancer patients impart a fraction of their anguished and dreadful individual existential selves, with a negative being-in-itself and an avoidance of being-in-situation attitudes onto the forum, which will serve as a cornerstone for the next step - the influence stage, where their original negative orientation towards cancer-coping will be challenged by others.

The Influence Stage

Chapter 5

"You're a priority, you're beautiful, important, special and worthy of all the support and love in this world. I'm saying that from my heart." - Lisa

I define the social influence stage as the phase where the manifested beliefs by experienced cancer forums interact with newly diagnosed members by contesting their pessimistic views after the realisation stage. It is social for it is interactional. This influence may be one of contestation or the provision of newer cancer-coping perspectives beyond the negativity of the realisation stage. In relating to my first research question, provided that one does not succumb to complications, there is an implicit stock of knowledge of a trajectory of growth through cancer, whereby one may eventually recover their confidence and self-image, albeit through a very slow and painful process. The influence stage is an intermediary stage between the realisation and internalisation stage, which involves the imputation of others' definitions into one's self.

'Objectivation' is the way whereby human beings manifest their own subjectivity in terms of human activity and products through typifications (Berger and Luckmann 1991:49-50). This is done through significations such as patterned bodily movements, gesticulations, symbols, language, or material artifacts, which embody human subjectivity and are objectised into the surrounding world (p. 51). In terms of my research, the subjectivities of cancer victims were objectivated into the discussion forum through the significations of encouragements, consolations, advice, information-sharing, catharsis, guidance, and casual conversations using

written language. Through language, users constructed a consensually held stock pool of knowledge, or the set of beliefs involving cancer-coping.

STOCKS OF KNOWLEDGE

Throughout my study, I found that a "stock pool of shared knowledge" was a necessity which legitimised the authority and credence of each other's communications, and that its absence caused miscommunication. Additionally, the presence of an undergirding set of background assumptions, that augments the "shared pool of knowledge" between patients which facilitates both openness and growth, avers to other studies of social interactions' impacts on cancer patients in cancer support groups (Love et al. 2012; Pinheiro et al. 2008; Sillence 2013).

I found that there were 5 cancer-coping stocks of knowledge common to many experienced cancer patients, which were learned through socialisation via the social influence of experienced cancer patients, and which helped to facilitate the existential growth process. The 5 stocks of knowledge are:

- 1) Embracing a Being-for-itself Mentality
- 2) Embrace of One's Being-in-situation
- 3) Accepting Being-toward-death as an Integral Part of Life
- 4) Feelings of Pain, Fear and Anxiety are Normal and there exists a Trajectory of Growth and Recovery
- 5) Vicariousness and Trust as Precursors to Empathy and Contribution

These 5 stocks of knowledge were learnt through the influence stage of the developmental model. Additionally, while Berger and Luckmann (1966) maintained that stocks of knowledge are culturally-held social background assumptions that are less subjected to change, my thesis presents a notion whereby these assumptions are sculpted by people, who then pass on to others to learn, and these new people in turn repeat and sustain the process. These stocks of knowledge in turn facilitate growth by transforming the evasion of one's being-in-situation and the maintenance of a being-in-itself attitude, to the opposite and positive ones.

1) Embracing a Being-for-itself Mentality

Social influences from other experienced members on the forum shaped the views of patients in the realisation stage. In the realisation stage, newly-diagnosed patients objectivated their negativities to the forum. In the influence stage, rather than having various cancer patient members reinforce that sense of helplessness, the opposite frequently occurred. To show a being-for-itself mentality is to show volition and reflexivity in aligning oneself with a positive mentality, rather than yield to hopelessness, powerlessness, and defeatism in an avolitional and non-reflexive being-in-itself attitude.

In a thread regarding doubt about survival in June 2012, Aprilyn, the original poster, wrote of her anxiety and enervation towards facing chemotherapy the day after. She was only recently diagnosed with stage II cancer.

"Ever since I got the biopsy result, I've kinda felt like I'm dying. [...] but it's like it takes too much energy to hope for the best. [...] I have to hope that life will be worth living during the treatment. I'm just having a hard time with that right now!"

Here, by feeling that she hopes that "life will be worth living" and currently "felt like [she's] dying", the future tense of the former and the present tense of the latter both imply a difficulty to accept life positively at the time of posting. In insinuating that it takes "too much energy to hope", she establishes herself as a powerless being-in-itself. Aprilyn, who has never had the experience of cancer, and was diagnosed on the same month of posting the above responses, was assured by Miriam, who wrote to her:

"[...] everyone here has felt that hopelessness. [...] YOU will feel better. Terrifying at first, but then I learned to accept it. You are right to have HOPE!"

Miriam is an experienced cancer patient who was diagnosed with stage III breast cancer on 12 January 2010, more than 2 years before posting this reply to Aprilyn, in early 2009. Additionally, in two earlier posts in May from 2 threads regarding painful and enlarged lymph nodes, she mentioned that she had a biopsy test and a subsequent breast implant that caused pain, implying that she has been through treatment. In the above quote, Miriam attempts to reframe Aprilyn's assertion by imbuing hope and melioration into her life, despite the initial terror.

Therefore, through language, individual negative thoughts and feelings, such as Miriam's and Aprilyn's shared understanding of hopelessness, counter-definitions against the terrors of

cancer, and the subjectivities of the self, are passed on and shared with others. This bridges the gap between the isolation of the "here and now" of individual existential states with the social world (Berger and Luckmann 1966:43), and allows others to influence oneself (Kotarba 1984:226), like Miriam's impact on Aprilyn. Berger and Luckmann (1966) wrote theoretically, without empirical substantiation on how stocks of knowledge are transmitted, but the findings above suggest that individuals are carriers of these stocks, which through language, evinced via writing online, are conveyed to other individuals.

Following Miriam's above-mentioned reply, Joyce also wrote in the same thread to Aprilyn:

"[Aprilyn], I was one who thought that my diagnosis was a death sentence. I started trying to "put my affairs" in [...] I became more a little more positive and decided that if i had 5 years or 10 years, I was going to make them good ones. [...] I still ride the roller coaster between periods of positivity and negativity."

Joyce was diagnosed with stage IIA, grade 2, IDC on 20 Oct 2011, and had no recurrence or metastasis since the removal of her lymph nodes, and was thus technically cancer-free at the time of posting. Using her past experience with initial diagnosis and by asserting that she did rather "make [her remaining 5 or 10 years] good ones" rather than see cancer as a "death sentence", Joyce re-situates Aprilyn's initial resolve to relegate her fate to death and to give up in a new light through positing an alternative route based on the acceptance of one's illness. This choice implies moving towards a volitional being-for-itself. People like Joyce therefore defined

the practical, alternative "socially-approved behaviour patterns" of positive cancer-coping, transmitting them to new members like Aprilyn (Schutz 1962:17). We see further this in Emma's post below, where she replied to Aprilyn as well:

"And stage II, grade III isn't a death sentence [...] Hang in there. Believe that the treatment you are getting will save you and give you a normal lifespan. [...] I still get waves of fear that wash over me, but then I just get defiant and go to the gym or another bikram class or do a long hike, and I feel better knowing that I'm still, post-tx, doing everything I can to flip the big old bird at cancer."

Emma was diagnosed with cancer 4 months before. Here, she wrote about her "waves of fears" from cancer, and, just like Aprilyn, she still gets occasionally distraught. However, by saying that she "get[s] defiant" in face of her "waves of fear", in the attempt to "do everything" to "flip [...] cancer", this suggests that the self is *reflexive and volitional* in between the initial dread and her subsequent transformation: instead of accepting Aprilyn's negativity, she reflected on her initial distress, refuted it, and then presented an opposing being-for-itself cancer-coping attitude. This is in accordance with theme one of existential sociology, in my literature review (ibid page 21) - the existential self is a "sentient self" that is intentional, interpersonal, receptive, and volitional, being "tested in interpersonal acts [...] and [open] symbolically to new possibilities" - such as by choosing positivity over negativity (Smith 1984:109; Manning 1973:212). Its capacity for sentience allows cancer patients like Emma to reflect on their quandaries, and choose to contest or accept the "new possibilities" granted to them by others, so as to integrate the accepted

parts into one's core being. Emma's case showed that some cancer-coping growth may rise through introspection when she asserted that cancer "forces [one] to look within."

Within the same thread, Selena also replied to Aprilyn:

"Ann- You are so early in your diagnosis [...] You will get through the crying in time and then you will work toward getting better. [...] Hang in there. You will get through the hopelessness. It's terrible and awful and depressing and sickening. [...] When you get going on treatment, you will get your fighting spirit back up. And we will be here to help you fight!"

Selena had a mastectomy 2 years before, and was completely cured of cancer. The above post shows how Selena's encouragement to the original poster compels the latter to proactively "get [her] fighting spirit up". May, seen below, also advises and reinforces this need to be strong notwithstanding the fact that some social relations may dissolve upon them realising the cancer diagnosis of the patient:

"[...] I would advise to be as strong as you can about what you do and don't want in terms of support. Some people will come into your life only because of the cancer and some will leave unfortunately [...] In hindsight, I should have set more boundaries, but it was all okay in the end."

The capacity to act and proactively find peace and strength, as shown in the last 2 quotes, notwithstanding external circumstances, is a hallmark of a Sartrean being-for-itself. Finally, the original poster, Aprilyn, then replied to Emma and Selena:

"Feeling 100% better today. My mental stuff seems to cycle. If I have bad morning, I'll have a good afternoon and vice versa [...] I finally told people in my wider circle about my dx. The support from that has been uplifting [...] I think most of the time I actually feel calmer and more peaceful than I did before the dx."

By saying that the support from Emma and Selena "has been uplifting" and that she feels "calmer" and more "peaceful", it shows that mutual consolations and support from such cancer patients helped to reconstruct inner peace by making Aprilyn feel that she was "not being alone with the disease". A patient's consolation by others may thus lead to other patients providing subsequent aid to other patients in a chain of encouragements (Pitts 2004:46), as shown in Emma's and Selena's subsequent encouragements following Miriam's, which reinforced positive stocks of cancer-coping knowledge, based on reconstructing inner peace and hope. Altogether, this dialectic with others facilitates an *initiation of change* from one's original being-in-itself, and maintains that the existential self is not separated from the world (Kotarba 1984: 226).

Aprilyn's Interaction with the Forum

The diagram above shows how successful interactions between Aprilyn and the forum members facilitates, through counter-definition, the formation of a being-for-itself mentality, vis-a-vis Aprilyn's original being-in-itself attitude. In summary, one's proximity to death predisposes one to urgent, immediate concerns with one's lives, as shown in the realisation phase. In the influence phase, this compels the existential, reflexive, thinking and emotive self to seek broader meanings with one's life. Pushed to the edge of contemplation, they enter the comfort of an online community, which encourages, counsels, and appraises them, helping to re-orient them from a being-in-itself to a being-for-itself mentality. Berger & Luckmann (1966) wrote theoretically, neglecting how stocks of knowledge are transmitted. In this section, I have shown that experienced members, such as Joyce, transmit these stocks through written language.

Aprilyn entering the forum to seek encouragement shows, as Kotarba (1984) wrote, that people constantly shape and sculpt society, using it as a resource to fulfil one's most rudimentary existential needs and desires (Kotarba 1984). This leads to self-transformation, which occurs through the interaction of one's self with society (Ferraro 1981; Rose 1984) in places such as online cancer support groups, which provide sources of external definitions that compel one to overcome their initial inadequacy to make choices and re-examinations that persuade one to give up their initial states as helpless being-in-itself-centered cancer victims. This helps them to begin to re-formulate and reconstruct a new hopeful self, evident in how Emma and Selena assured Aprilyn to do such. The counter-formulations on the forum, as objectivated and habitualised by more experienced members, provided a redefinition based on being-for-itself that tries to address the newer users' existential needs.

2) *Embrace of One's Being-in-situation*

The embrace of one's being-in-situation involves the audacity to face the tribulations or problems of cancer, followed by the proactive means to overcome cancer's challenges. It subtly differs from being-for-itself, in that confronting one's being-in-situation is a more *immediate and present* attitude and courage to accept and proactively overcome one's current tribulations, while adopting a being-for-itself mentality involves *volition, reflexivity, and a focus on the future*. To achieve this, social interactions allow the experiences of others to remind the help-seeker not to be purblind to the blessings that one already has and to adorn a broader perspective that re-situates the self in broader existential meanings. This must be coterminous with courage to make

cancer a lesson to be overcome than reviled, and online support greatly provides the opportunities to encourage users of this very poignant but necessary step to growth.

In a thread on moving past cancer, Caroline, the original poster, wrote in June 2011, that she had a bilateral mastectomy of her stage 1 IDC in 2008, and had no recurrence since. Though cured, she had yet to fully overcome the problems caused by cancer to her life, as she wrote:

"Now nearly 3 years later it is still at the front of my mind [...] I understand that however I need to figure out how to move on and be thankful for the here and now. I am wondering if others feel the same way and how they do that."

Caroline's post was reframed by Diana's reply:

"[...] we have to figure out a way to use it for good, or we will continue to be a victim. [...]"

Diana was, at the time of replying, a cancer survivor who was diagnosed with stage IIA, grade 3, breast cancer in 2008, and had since removed 16 lymph nodes, with no signs of recurrence or metastasis. The confrontation of one's issues requires not just a simple change in attitude, but a need "to reconceptualise the meaning of life [by] developing new 'normals' of being in the world [and to] experience a rebirth [...]" (Laranjeira et al. 2013:136). This requires, on the online cancer forum, the provision of an "alternative means of coping" by other members where "heeding veterans' advice would help newer members move even further along the path of

a fulfilling life" (Williams & Goh 2015). This is evidenced above, where Diana redirects Caroline's fears towards an alternative means of coping, suggesting that when entrapped in a trauma, resolution involves growing *out of* the problem by treating it as a lesson. Thus, this emphasises the ineluctable interactional effects from others on the individual patient during the influence stage with

There was also a socio-interactional process where senior members, legitimised by their cancer experiences (see page 73 for the definition of 'legitimation'), attenuated the severity of the newer members' pessimism and despondence, by suggesting their own positive cancer-coping methods. Mabel wrote in the same thread:

"I am feeling so foolish and weak [...] almost two years later and I am still go over and over it. I can't seem to let it go. [...] Every night as I am "trying" to go to sleep I think about getting BC again. Certainly I am worried about getting it again but I think I am feeling a void without it. [...] Why can't I feel blessed and move on?"

Mabel finished her cancer treatments on November 2010, 2 years before writing the post. Her posts were paralleled by Xena, who also wrote that she was "unable to move on" due to cancer, and that she had "[contemplated] cutting short [her] own life." The remarks of Mabel and Xena thus involve the effusion of a negative avoidance of one's being-in-situation through the inability to get past the *present*. This was later repudiated by Jessica, who contested their negative views by offering an alternative, to simply "find new interests" and to "stay positive".

"[...] moving on was hard for me as bc 'took over' my life for over a year - surgeries, treatment, medical appts, followups, and frankly just plain tired - hang in there and yes stay positive but don't beat yourself up if sometimes you just feel a bit down - find new interests or renew old ones [...]"

Jessica formerly had stage 3A ILC, although an investigation of her posts suggests that she has been cured of it for 10 years, without any recurrence. A study of her other threads suggests that she has been constantly encouraging other newly-diagnosed patients on the forum, and therefore, she could be said to be an experienced cancer survivor. Berger and Luckmann (1966:111) wrote that legitimisation (also spelled as legitimation) "tells the individual why he should perform one action and not another". By providing vicarious examples of the painful procedure of cancer through her initial year, and her ethos to not "beat yourself up" even if one "feel[s] a bit down", Jessica legitimised the weight of her advices using her experiences by suggesting that one way of dealing with one's being-in-situation is not to submit to an ongoing self-destruction and self-loathing. By repudiating Xena's negative remarks, after Mabel's, there is evidence to suggest that a continued spiral of negativity (from other members agreeing with the original poster's negativity) is curtailed on the forum. The next sub-section (ibid page 76) covers these more deeply by covering the levels of legitimations, and on how such "spirals of negativities" are negated and regulated by others more directly.

Jessica was also agreed upon by Karen, who wrote:

"So I just suck it up and keep on trying. [...] people think you are nuts when you tell you are dreading [...] BUT I truly do feel blessed most of the time but all of this just kinda peeks its head in to remind you."

Karen was diagnosed with grade 3 breast cancer on 2009, but has since removed 4 cancerous nodes, and is now free of cancer. Just like Jessica, she posts messages on the forum to encourage other patients; one of which includes a thread on depression, where she listens to the suffering of others and offers consolations frequently, by using her own experience to empathise. She is thus an experienced cancer survivor. In the above quote, her motto to simply "suck it up and keep on trying" parallels an adamant fortitude towards focusing on the "now" of one's being-in-situation with fortitude, through her usage of present continuous tense. The acts of Jessica and Karen show how experienced cancer survivors offer counter-statements against comments such as Mabel, who paint a chapfallen attitude towards life. This maintains a stock of knowledge of cancer-coping involving a confrontation of one's being-in-situation.

Interactions within the current thread

The above chart shows the interactions within the examined thread. Summarily, in Bergerian language, the set of cancer-coping beliefs on the forum is a symbolic universe that "provide[s] the delimitation of social reality" (Berger and Luckmann 1966:120). Mabel's, Xena's and Caroline's negative way of cancer-coping were influenced by Jessica, Diana, and Karen, who provided such a "delimitation" by offering positive prescriptions on how to cope meaningfully. Originating from incipient "subjective reflection" in the realisation stage, seen in Mabel and Caroline, to the "objectivation" of an embrace of being-in-situation in the influence stage by experienced patients like Diana, Jessica, and Karen, this symbolic universe, comprising of the generalised stocks of knowledge of positive cancer-coping, is maintained by its individual members through the refutation of negative cancer-coping attitudes. One's experience of having

been through the worst episodes of cancer lends legitimation (seen in Jessica) to the experienced users' words. The dominant discourse of cancer (in real life, beyond the cancer forums) is one of avoiding one's being-in-situation, where the experience is seen as largely negative. However, the influence stage is one where the individual existential self converges, and are modulated by the presence of other members, who provide counter-hegemonic definitions against this dominant discourse using the forum's maintained positive cancer-coping stocks of knowledge, by shifting one to the embrace of one's being-in-situation.

3) Accepting Being-toward-Death as an Integral Part of Life

Heidegger (1962) explained that there is a difference between seeing *death-as-actuality* versus it as *death-as-possibility*. Both involve accepting that death is inevitable. However, the former sees that there is nothing one can do in between one's current time to that of one's eventual death. The latter, however, sees that one can choose to be productive and felicitous between the two times.

In this section, I shall mainly analyse a thread about the fears of dying, originally written by Gwendolyn, a stage IV cancer experiencer who wrote about her fears of dying due to cancer. Here, she wrote:

" It feels like all of the anger and sadness has all rolled up into one big ball of hurt and pity [...] It feels like I am Mourning my own death [...] and it tears me apart [...] No one knows how or when they will leave this earth.."

Gwendolyn was only diagnosed with cancer only months before posting the above. These established Gwendolyn as a cancer experiencer who is going through the ongoing realisation phase of cancer, as developed in my model, with a being-as-actuality attitude that "mourns [her] own death" instead of putting her remaining time to good use. However, during the social influence stage, Freyda replies to Gwendolyn, saying:

"[...] Death is a part of living. [...] I do have control over how I am going to live my remaining days here on earth. My plan is to Live and Love (and party) as much as I can NOW. ."

Freyda is an experienced cancer patient who had 7728 posts on the forum. She was diagnosed with stage IIIC IDC at 40, but had been cured, only to have a recurrence at 2007. She had radiation therapy, hormonal treatments, and a hip replacement. Encouragements, like Freyda's, are important as hearing each other's stories of cancer survivorship and tribulations leads to positive affirmations of one's life (see also Shannonhouse 2014; Afshari, Ghani, and Radzi 2011). Some encouragements may be seen as "first-order legitimisation [also written as 'legitimation'] of meaning" (p. 110). A first-order legitimisation is based more on an individual's modus operandi of cancer-coping, such as Freyda's, who offered concrete means of coping (her plan to "live and love [...] now"). By providing these means, Freyda helps Gwendolyn to accept that "death is a part of living" but one can still make good use of it, through a shift towards seeing death-as-possibility.

How about higher orders of legitimation? Taylor wrote a summary of a book on cancer-coping that she had read within the same thread, replying to Freyda:

"We just live our lives and push things like death into the subconscious. But with a cancer dx, it becomes very real because so many people die from cancer so we think of death more. But death is a fact of life [...]"

Second-order legitimation involves "theoretical propositions in the forms of "proverbs, moral maxims and wise sayings", like Freyda's adage that "Death is a part of living" (Berger & Luckmann 1966:112), and Taylor's summary of a book. This is further substantiated by the writings of Kai and Saffi, who in, short, pithy maxims, captured the essence of Freyda's words, within the same thread. Kai wrote: "Just because we have cancer does not mean we will not be here tomorrow, while Saffi wrote: "The only way I deal with that is to know that no one is guaranteed tomorrow, and I am going to live today as well as I can." These aphorisms (Freyda's "Live and Love") may compel new members to question and shake their beliefs (Rose 1984:163) from seeing death-as-actuality.

Additionally, first and second-order legitimations "explain the institutional order by ascribing cognitive validity to its objectivated meanings" and provides normative guidelines that sustain the cancer-coping beliefs on the forum (Berger & Luckmann 1966:111). I have found that this was done through the invocation of biblical scripture, reinforced by a continuous number of responses to each other's posting of such. Raelin, for instance, wrote of her biblical studies in the hospital:

"I started and ended in Psalms, I ended up looking at the room as the cave David was hiding in while he was writing what I was reading. It gave me peace [...] I tried to explain that before I could be filled with the joy and peace God promises us [...] there's still some sad left in there, but I have His promise and cling to that."

Saffri in turn wrote:

"God is always with me and it is his decision when I come or go. I know that he needs me here for my parents and for my husband. My disease is nothing compared with the needs of their love. [...] Thank you God."

Altogether, these biblical quotes, as second-order legitimations, anchored the patients to reality, giving them strength and peace, in times of the sadness of Saffi and Raelin. Drawing from examples in the bible, such as David, normative guidelines on coping despite imminent death before one "come[s] or go[es]" were drawn, reinforcing the validity of maxims by people such as Freyda, Kai, and Saffi.

Although her treatment was still ongoing at the time of replying to Gwendolyn (and till 2015), Freyda wrote: "I can say I feel like I am on the road back. [...] I am going to try to lead a normal life with BC just as a footnote." The present tense used shows that existentially, she was in the process of cultivating the management and coping skills to cope and reach pre-morbid normalcy. In her response, she re-constitutes Gwendolyn's original *weltschmerz* towards life by

re-situating her to see death-as-a-possibility, following the realisation of one's being-onto-death. This means that despite the inevitability of death, one still has the choice between now and death to give value to one's life. Shaw et al. (2000:149) similarly found that "seasoned participants" in support groups shared their testimonies with newly diagnosed women to ease their cancer's passage, showing that if they have done it, so can Gwendolyn.

Therefore, in a way, many cancer patients pro-actively coped with cancer through managing their lives, and living with acceptance, instead of resigning to the fate of death passively. As assurance, in the same thread, another user, Lori reassures Gwendolyn, the original poster:

"[Death] is coming sooner rather than later because of the nature of our illness. [...] Enjoy everything you have and live your life to the fullest while you can. You have the gift of being able to appreciate the gift of life and really enjoy precious moments as they happen and not just take life for granted. "

Lori was diagnosed with stage IV metastatic and recurrent IDC in 2006, with her initial diagnosis at around 2000. Additionally she has around 8711 posts. I examined many of her posts, and found that she gave technical advice to others, using her experience, like the following: Chemo embolization, liver resection, and sir spheres (see glossary). She has also created threads on how to deal with one's husband during cancer, metastases to one's liver, biblical studies, fatigue management, bone treatments, and managing one's mother with cancer at a hospice. All these show that she is an experienced ongoing cancer patient with much skill and wisdom in its management.

In Gwendolyn's original thread, Lori consoles Gwendolyn's pessimism using her vicarious experience with cancer to guide her towards not being pessimistic or worrisome about the future *and* that despite the imminence of death, one can still appreciate and make best use of life before one's end, following a Heideggerian death-as-possibility. Socio-interactionally, Williams and Goh (2015) found that veteran members on an online BC forum helped new members about options to "choose to live" and cope with cancer through personal examples and analogies to help new members connect to such. Kissane et al. (2004:764) also found that support groups led to the sharing of stories that eventually help members "accept their limited future" despite knowing "that [they] will die". They added that this sharing transforms the "existential ambivalence" of dying (from being-toward-death) into "creative living [...] celebration, altruism, and new creative pursuits". Thus this emphasizes the interactional impacts that facilitate the confrontation of one's being-unto-death in a sociological, rather than as an individual and purely psychological manner, towards death-as-possibility.

Interactions within the current thread

The graph above shows the interactions within the examined thread, where more experienced members brought forth first and second-order legitimations, such as the invocation of biblical verses by Raelin and Saffi, and mottos to live, from Kai, Freyda, and Taylor, to influence Gwendolyn towards seeing being-as-possibility.

From the above-studied thread, I found casual references to another thread about someone in "not wanting to die". These findings, I felt, were sufficiently important for me to report here. On the forum, it was a common practice for members to delete their own messages, or with the intervention of a moderator, to avoid impinging on the sensitivities of others. Though I was unable to trace the deleted messages in this referred thread, I was able to infer the context

of what had happened by continuing my analysis of this current thread (that is, Gwendolyn's thread on the fears of dying). Gala originally wrote:

"After reading [Rayleigh's] post again, I am so scared right now..I am afraid that no one will take care of [my family] When I first came to the boards, I looked at [Rayleigh's] stats and they were the same as mine.. I thought that having a grade 1 cancer gave me more time but it wont.."

Originally, Rayleigh had most probably posted a thread on her extreme fear of dying from her stage IV cancer, which was then deleted, based on inferring from the subsequent messages. I could not find the original deleted thread, but within the current thread, this fear was in turn abated by Janis, who wrote to Gala:

"Do allow yourself to grieve, cry, scream, mourn, et al, we're all with you. Each one of us has lost a part of ourselves to breast cancer, not by choice, but just by circumstance; the bad luck of the draw; destiny; karma, whatever one chooses to call it -- no one on this earth knows why."

Parker also wrote to Gala:

"Keep your hope alive, and enjoy your family and friends as much as possible now. When I look in the mirror I know that woman is still down there, and every day I work to bring her back for at least a little while."

On checking the background of Parker and Janis, I have found that both were stage IV IDC sufferers with metastatic cancer at the time of posting. It was not known if they survived till today, as their last post was within the same year of posting itself.

Rayleigh, who deleted her original posts, responded to Gala:

"I am so very sorry I made you frightened. This was never my intention. And, most importantly, love to live [...] Don't waste too much time being afraid. Its too much of a waste when time is precious."

In the above post, Rayleigh retracted her original post (by deleting it), deemed by many others as being frightening. This was later addressed by Irina, who wrote to Rayleigh:

"Dear sisters, I think we don't have to apologize. This is place for us. We can share what we feel. [...] We all are strong but we all have scared moments. (((HUGS)))"

Despite the objection to her frightening post, Irina reinforces the idea that it was fine to vent frustration since they are in same boat, to a certain extent. The fact that Rayleigh deleted her original post suggests that members such as Gala's effusion of fear may play a direct gate-keeping role in influencing the former to remove her original post. The "damage-control" exuded by Janis and Parker shows direct methods in which a positive stock of knowledge, of accepting death and enjoying life (that is, maintaining a death-as-possibility attitude even in face of one's being-toward-death), is maintained, and where others, like Irina, stipulated the extent of what

content was permissible, establishing norms against some extremely threatening negative cancer-coping mindsets. This skews the stocks of knowledge towards positive ones that are more facilitative of growth. The graph below summarises the interactions within this thread:

Interactions within another referred thread

In summary, as introduced at the start of this chapter, the influence stage is a transitional stage between the realisation and internalisation stage, which involves the infusion of the definition of others into one's volitional self. In Johnson's (2002) study of the existential self, the volition to perform an action comes from a confluence of such social influences and individual factors such as earlier life and relational experiences, suggesting that this stage is a confluence between self and society. It is also one of contestation and negotiation between the two nodes. Just like in my study, the 'gate-keepers' of socialisation like Lori, and other less experienced members like Saffron, Raelin, and Taylor used first and second-level legitimations to imbue

"general moral rules and values" in a social group (Kotarba 2002:117-123). Additionally, the drama which ensued from Gala's post (Rayleigh's deleted thread), and on how negative cancer-coping attitudes towards one's being-toward-death were mended by members like Janis and Parker. The use of such gate-keeping "damage control" maintains the cancer-coping stock of knowledge of accepting death as an integral part of life and making best use of it. This partially answers my first research question - that there is a trajectory of growth over stagnation, against a prior view centered on seeing death-as-possibility, instead of a actuality, following Heidegger's terminology.

4) Feelings of Pain, Fear and Anxiety are Normal and there exists a Trajectory of Growth and Recovery

On the forum, there was a stock of knowledge that involved the realisation of the tribulations of cancer as normal, and that one may grow out of it. Christine remarked on Feb 2012, in a thread on how long it took to find acceptance and recovery, 2 weeks after diagnosis with stage IIA IDC:

"I had my diagnosis confirmed on January 16th so perhaps it has not been long enough for me. But I alternate between depression (when at home), denial (when at work - it's wonderful), and a combination of shock, denial, and panic when I see the doctor, have a test, etc. A part of me just wants to forget the whole thing and just move on with life, and not get any treatment."

Aliya replied to the original poster, Christine:

"How do we cope, well me I cried for a week then said no more [...] The first thing I did was give up the wine because it would make me feel worse down in the dumps. [...] Take every day as it comes never looking too forward. Carry on as things were before and do things you like [...]"

In here, Aliya evinces to the original poster, Christine, that the cancer voyage is initially rife with pain. Haili also wrote to Christine:

"Many of us have ups and downs for the rest of our lives it doesn't ever go away entirely but hopefully in time and with good health, it becomes easier. [...] Still with some fear, but that is getting better. Still having pain and fatigue, but that, too, is getting better [...]"

Haili's response suggests that the tribulations of cancer, such as "pain and fatigue" are normal, but one may eventually recover from such by "getting better". This is reinforced by Lilith, who wrote:

"[...] acceptance comes, and sometimes goes as well! I have been on this journey for 2 years. Initially I woke up every morning thinking it was all just a bad dream. [...] I would cry my eyes out. Denial has been very strong in me since the beginning [...] I pretty much lost my enthusiasm for anything with the recurrence just 6 months after I finished chemo [...] I have been doing a lot of minfulness-based practices training and learning to "just

be" and acknowledge and accept that there are moments of fear, panic, sadness, grief, depression. But most of us have been able to move that direction, and you will eventually do so as well."

Lilith is an experienced cancer patient who was diagnosed with cancer on 2010 (Stage IIIC), and twice more with recurrent cancer on 2011 (Stage IIIC), and 2012 (Stage IV IDC). In the above, Lilith assures Christine that "fear, panic, sadness, grief, depression" are normal but could be overcome "as well". Therefore, through reassurances that everything one feels is absolutely normal and that they will cycle a lot, by Aliya, Haili, and Lilith, patients like Christine were socialized to acknowledge that the cancer voyage is one rife with hurdles - but they are not alone in this path, countermanding the initial hopelessness of the latter. Love et al. (2012) comports with this, mentioning that through the sharing of thoughts such as the commonality in diagnostic and prognostic experiences, cancer patients would validate each other's statements by attesting to their experiences by using "positive re-framing, or venting" - as seen in the interactions of Christine, Aliya, Haili, and Lilith in this sub-section, who reframed Christine's original hopelessness into positivity. Ultimately, a positive cancer-coping stock of knowledge regarding the normalcy of one's initial tribulations, but also the capacity to overcome them, is maintained on the forum through such positive reframing.

In relating to my first research question, if one does not succumb to death, there is an implicit stock of knowledge of growth through cancer, whereby one may eventually recover, although slowly and painfully. Continuing the above argument of the normalcy of the cancer

journey, I continue to examine the current thread. Erza, another experienced member, wrote to Christine, the original poster:

“I think I enjoy life much more than I used to and particularly the simple things.[...] I think to myself that going through the breast cancer diagnosis and treatment has made appreciate so much more.”

Cancer patients grow by changing "some of their [...] worldviews and gave rise to feelings of self-acceptance and self-realisation" (Brunet, Sabiston, and Burke 2012:348-350), and by realising that cancer is not just seen as a gift, but a "second chance" which leads to more flourishing after surviving (Keim-Malpass and Steeves 2012:377). Erza's post manifested this post-traumatic flourishing of life's appreciation, while simultaneously providing inspiration to others in the earlier phases of treatment.

Interactions within the thread

The diagram above summarises the interactions in the studied thread. In synopsis, the sharing of one's growth experiences provides hope, which assists in the patient's existential shift towards the acceptance of the normalcy of pain and one's eventual existential recovery. This then elevates others to embrace such hope, as shown in Aliya, Haili, Erza, and Lilith's countermanding of Christine's original dread that cancer did not offer recovery, into its opposite.

I shall continue with my sustained analysis of this thread, by Christine, in the next chapter, where I bring evidence to show how the influence stage leads to internalisation by junior members.

Redefining one's present and past were other ways of recovery, through seeking acceptance towards their "new normal". The above thread made casual references to another thread which involved finding one's "new normal". Therefore, I traced the original thread and investigated it. Here, Raven, the original poster, so lucidly adds:

"this entire experience has taught her that a breast does not make a woman, nor does it make a woman beautiful [...] I am proud that I can teach [my daughter] that lesson."

Others, like Cassie, also wrote on the same thread, dismissing their husbands' ambivalence towards their breast removal with the acceptance that this deed has been reconciled with normalcy. Others, like Bella, redefined having flat breasts as a conquest trophy over cancer, saying that her flat breasts are "like [her] shield and [she] wears it with pride", showing that she has "fought cancer and won!" By being honest towards their breast modifications, it was then possible for one to confront societal ambivalence towards such, and transform it into pride.

Breasts were not the only things being redefined in light of cancer-coping - many patients suffered from depression during the journey, and viewed more stoically towards their melancholy. In the same thread, Brenda inverted the traditional notion of depression by asserting that "depression is not a sign of weakness. It's a sign that [one has] been strong for too long". She perseveres by suggesting that this assertion made her "feel more normal and gives [her] strength". Ulrica agreed with her and offered her own counter-definition, that "depression is anger turned inwards", alluding that this allowed her to "make it through [her treatment]".

Others redefined the nature of their lives to cope, but this could only be achieved, firstly, by opening up to the reality of cancer. Bella did both by asserting that she was "trying to make breast cancer [her] blessing [and] not [her] curse," by "not going to allow it to control [her]". Rose wrote that "life is not measured by the number of breaths [one] takes, but by the moments that take [their] breath away," emphasizing therefore that one means of cancer-coping is to redefine life through the quality of positive, memorial events, than the quantity of mere longevity. This redefinition comports with Pierret (2003:10), who found from the illness experience, that some individuals redefined their self to cope, by "reconstructing biographies or renegotiating identities". Others used 'normalisation', like Brenda, by writing, in the same thread, that "my illness had no impact", although this is limited for those with severely crippling diseases, where the tension between the "person's private self and public social identity" is greater (Kelly 1992).

Lastly, many patients on the forum defined themselves as "breast cancer patients", against the divisiveness of separating themselves into different stages or grades, as Belle wrote in the same thread:

"I don't post my stats for that reason! I am not a stage or grade. I am a breast cancer patient [...] this is the last place we need to divine [divide] ourselves here, with a pecking order of who suffered the most, or who is in a more advanced stage."

By honestly acknowledging that they are all one in the same boat, camaraderie and solidarity are reinforced through the partaking of a single social identity.

These new findings show that perhaps, while one may analyse the existential states of cancer patients through redefining oneself to existential categories like "being-for-itself" or "embracing one's being-in-situation" from their opposites of "being-in-itself" or "avoiding being-in-situation" - there is a potpourri of other non-existential redefinitions to assist in recovery, that were excluded in the deduced categories of this research, such as the normalisation of cancer through the acceptance of one's breasts, depressive states, and as breast cancer patients.

5) Vicariousness and Trust as Precursors to Empathy and Contribution

Perhaps a highly important stock of knowledge that renders the interpretation of encouragements or advice is the shared vicariousness of cancer common to all members that grants authority and legitimacy to their words. This stock of knowledge differs from the other stocks, as it is not something which is socially constructed and sustained by the cancer patient forum users. On the contrary, this pre-exists throughout all 4 stages of a cancer patient on the forums. Its pre-existence is important, as without this, miscommunication would arise, as demonstrated earlier, such as with non-cancer experiencers.

Berger & Luckmann (1966) maintained that significations are signs which embody human subjectivity and are projected into the surrounding world. Likewise, the social production of knowledge on a cancer forum can be propagated through encouragements, exchanges, consolations, advices, jokes, or catharsis. Mead (1938:8) maintains that there are two kinds of symbols: first, interactions which involve the transfer of symbols between two individuals such that no meaning is incurred, thereby resulting in no further action or interpretation. Second,

"significant symbols" involves the mutual comprehension of each other's actions, leading to interpretations and re-formulations of the meaning imbued in each action, which then again re-shapes actions. Meadian "significant symbols" on an online cancer forum may include words of encouragement, approval or disapproval towards another patients' actions with the intended and shared meanings between sender and receiver. These assumptions of background knowledge provide "systems of relevancies" similar to oneself (Schutz 1962:12) that allow for a "reciprocity of perspectives" (1962:11) to allow individuals to act, by anticipating the actions of others.

While non-cancer experiencers may not share such a stock of knowledge, other cancer patients and survivors on the forum have their interactions greatly facilitated and *enabled* through such a requisite necessity. By knowing what others know, one can communicate with them meaningfully and reciprocally. As Diana wrote: "If someone doesn't hear thier name and breast cancer in the same sentence, I doubt they truly understand." The totality of these shared experiences and problems constructs a mutual empathy that expunges miscommunication arising from crossing each other's sensitivities and enables constructive discourse. The latter can occur out of the breast cancer women's experiences which fall outside others (non-cancer experiencers) common sense (Pitts 2004).

Evidence from a thread involving the insensitivities of other [non-cancer] individuals were gathered. Sarah wrote:

"I have a close friend i talk to everyday but have spoken very little about recently finding out I had DCIS. [...] So then he says, "Well it's not Official Cancer is it?" lolKinda caught me off guard :S"

By being "caught off-guard", Sarah reacted to her friend who crossed certain sensitive boundaries due to a lack of background knowledge about DCIS being cancer. This was substantiated by Lora, who wrote: "The first thing my MO said to me was "Congratulations! You don't have cancer. We don't consider this cancer". Jane also wrote: "You are just too young for this." - no sh*t sherlock...like c'mon are you telling me something new here...my only response to that is to shrug and go "You're tellin' me." In the broader context, people's attempts to help assuage the pain of cancer through its denial were reacted to with shrugs of doubt. Sarah reflected surprise by saying: "Wow! I can't believe your MO of all people said that to you!" This surprise was then reciprocated by Ava's annoyance, who wrote: "That's exactly what my MO said to me yesterday! Did you keep your MO? I am not sure what to-- [...] It just bugs me." In Diana's words, a lack of vicarious experience and shared problems render medical practitioners, friends, colleagues, and family member to be unable to "truly understand", resulting in surprise, annoyance, and doubt which stymies communication.

By having commonalities in each other's experiences, this allows for a certain "taken-for-grantedness" which provides the frameworks for social exchange (Berger and Luckmann 1966:82-83). The evidences above suggest that non-cancer experiencers lack the typificatory schemes and taken-for-grantedness that render meaningful communion possible and free of misunderstanding.

How then, does a shared stock of knowledge of vicarious experiences and issues contribute to empathy and understanding between forum patients? Beatrice indicates in the same thread:

“[...] i thought i was going to drop dead the next day from the cancer but found this site and have found many woman with the same as me still alive and kicking.I think between pulling some strength from the wonderful people on this site and time passing you will be stronger and more accepting”

Therefore, the empirically-tested mettle and fortitude of the forum members' unyielding capacity to cope with vibrancy and vigor grants weight to the inspirational worth of their messages and assistances, by making one feel "stronger and more accepting" through "pulling strength from" similar people, as opposed to comments based on benightedness by non-cancer experiencers.

The awareness of one's angst arising from one's confrontation with possible death was also related to by many patients, as Claire relates to Karen: “I can relate to the disbelief [of being diagnosed with Ductal Carcinoma]. [...]” Finally, patients also related to the peripheral problems *around* cancer, such as having family members who similarly had cancer, as Karen wrote to Mia: “I can definitely get where you are coming from [of Mia's numerous family members, including herself, being diagnosed with cancer].”

This mutual relation is made possible only because the underlying meanings and experiences are shared, resulting in communicable Meadian significant symbols (ibid page 94). As Pinheiro et al. (2008:735-736) had patients declaring: that having "people who underwent the same thing as [they] did" increased their capacity to relate to each other. Having had cancer is a necessity for in-group status before sharing experiences (Afshari, Ghani and Radzi 2011; Love et al. 2012). Sarah, Beatrice and Lora's conversation emphasized this requirement. Thereby the shared, vicarious experience of cancer reinforces the mutual understanding and empathy which undergirds many meaningful online emotional and experiential transactions.

In summary, vicarious experiences become an enabling force behind empathy and authority. Vicarious experiences allow for a mutuality of understanding which grants more experienced members the authority and legitimisation to guide less experienced members, while allowing many members to "speak a common language" which facilitates their mutual exchanges to avoid misunderstanding and insensitivities. This foundational mutuality undergirds all previous stocks of knowledge, rendering them possible and legitimised, which supports the formation and sustaining of the cancer forum's "symbolic universe".

THE INFLUENCE STAGE: A SYNTHESIS

As seen in the above chart, this section relates to this thesis's second research question, by showing that the influence stage is the second phase of the socio-interactional process whereby one's initial "non-cancer-coping" beliefs, such as evading one's being-in-situation and being-for-itself were subjected to refutation by other more experienced forum members. The latter individuals draw from the existing 5 cancer-coping stocks of knowledge, objectivates and habitualises them, to cause the former to question her beliefs.

If the realisation stage is where individuals realise the harsh *actuality* of the powerlessness and possible annihilation that comes from cancer, then the influence stage *predisposes* patients to reflect and *potentially* discard a prior self that is not agreed by the forum's prevailing cancer-coping stocks of knowledge through social interactions, by opening them to the *possibility* of a positive cancer self. A chain of counter-definitions from more experienced members contain the initial negativities that new patients bring to the forums, through the imputation of the 5 positive cancer-coping stocks of knowledge. The 5 stocks of knowledge are undergirded by vicarious experiences which provide the foundational pillars of understanding and empathy that render the "symbolic universe" possible. Emotion exchanges then allow patients to commiserate with one another, therefore validating each other's inner states. This provides first and second-order legitimation, which motivates newly-diagnosed members to trust the experienced users' counsel and advices, which then slowly influences them to question their prior negativities, such as a being-in-itself and death-as-actuality belief, and raise the possibility of evolving towards a more constructive one.

This chapter also relates to the third theme of existential sociology, as covered in my literature review (ibid page 27): as existential sociologist, Altheide (1984:177) found, media sources such as online forums, form a "nexus between self-feelings and self-other definitions and expectations" - the daily lives of cancer patients are influenced through a dialectical process of "acquisitions, enactment presentation, reflection, and feelings about oneself as a focus of media attention". This tension that arises from a dialectical confrontation between the self and society, here being the cancer patient and the cancer forums respective, compels individuals to start to

create the new post-realisation existential self through social influences (Patrick and Bignall 1984; Smith 1984; Kotarba 1984; Manning 1973).

The Internalisation and Externalisation Stages

Chapter 6

"I will see that light at the end of the tunnel that everyone assures me is there" - Christine

"You will down the road be giving advice and encouraging other newbies" - Celeste

Internalisation is the third stage of this developmental cycle. The examples presented below were selected from those that were transitioning from the stage of being influenced by others to discard their prior existential views, to a stage with the new views. Therefore, if the influence stage in the previous chapter explores the thrust of external, social factors in compelling a person to shift existentially, the internalisation phase is marked by the gradual, transitional, painful but *not yet fully permanent* inner shift to a more growth-oriented worldview.

Internalization is “the immediate apprehension or interpretation of an objective event as expressing meaning” (Berger and Luckmann 1966:61), that is, the process through which individual subjectivity is attained. Internalization means that “the objectivated social world is retrojected into consciousness in the course of socialization.” (p. 61) A newly-diagnosed cancer patient that has internalised the new modes of existential authenticity has a phenomenological understanding of the nexuses of the embrace of being-in-situation and being-for-itself.

Externalisation is in turn the demonstration that one has internalised the art of cancer-coping, with a subsequent external effusion of that internalisation. Berger & Luckmann (1966) explained that human subjectivity is externalised to society through the assistance of language,

which in turns contributes to the stock pool of knowledge. This then causes individuals to internalise such socially constructed truths through the course of primary and secondary socialisation, and perceive them as subjective reality (p. 84). Thus externalisation is defined as the means in which people materialise their inner beliefs into the social world, in congruence with a new post-traumatic cancer-coping self. One who has reached this stage is ready to provide pedagogical guidance to those in an earlier phase of their journey. Unlike the internalisation phase, whereby a patient still shows some ambivalence towards the adoption of her worldview, and thereby require social support and approval to abate the uncertainties of this transition, people at the externalisation phase have a more solid anchorage in their new worldviews (unless triggered by another metastatic recurrence - see chapter 7), and are now strong enough to manifest this strength to others, with greater security and confidence. The evidences in this chapter were mostly from patients who have, based on my research, overcome the hurdles of cancer.

They share a few, if not all of the following characteristics: First, they have been present on the forums for many years, and have hundreds, if not thousands of posts. Second, they are now cancer-free. Third, if they are not cancer-free, due to recurrence or ongoing stage III or IV breast cancer, they have shown in their posts, that they have adopted a movement to each of the growth-oriented existential dimensions covered in this thesis. Lastly, they spend a lot of time and effort coaching and guiding the next generation of newly-diagnosed patients, or people who are still struggling with the transition away from stagnation-based existential dimensions. This distinction between experienced and inexperienced cancer patients holds in many instances, but I have realised that for some cases, the demarcation between the two is often subtler - some

members may fit this description, but may re-experience a recurrence of cancer, which causes them to regress back into dread and hopelessness. Although this is rare, their occurrences suggest that there are limitations to this dichotomous model, which do not hold true for all instances. Not all patients eventually reach this stage - an example is Caroline (ibid p. 65), who has remained in incertitude even after three years.

The following section provides evidences to show that many patients (i) first internalise these cancer-coping beliefs and then (ii) externalise their new beliefs onto others, thereby shaping the latter's beliefs in the influence stage through significations such as encouragements, verbalisations, counsel, catharsis, and support. This is done by tracing the replies of senior and experienced members.

INTERNALISING A BEING-FOR-ITSELF OVER A BEING-IN-ITSELF MENTALITY

In chapter 5, I discussed how Aprilyn said that she has "felt like [I'm] dying" ever since she "got the biopsy result" in July 2012, in a way that "takes too much energy to hope for the best." Subsequently, Miriam and Joyce influenced her to lead a *carpe diem* worldview. Aprilyn returned a month later, and mentioned:

"[...] now I come back and find all these wonderful stories and support. [...] I am not feeling hopeless any more. The initial panic I was feeling since dx has passed. [...]I still haven't settled on whether to try to believe in best case outcome, or try to somehow live well in the face of the uncertainty, but it's getting easier. I guess acceptance is a process. "

This replying message, with a focus of the phrases "getting easier", "is a process" and "still haven't settled" alludes to a slow momentum and transition from a point of existential panic and hopelessness to one through the gradual process of acceptance and coping with the uncertainty that accompanies cancer through the provision of social support, rather than purely from one's own strength. The internalisation stage is where the decision to discard the prior cancer-as-disconcerting and distraught self crystallises. Rose (1984:168-169) described this as a "turning point", where one creates the "ex-role, by re-establishing oneself in a new identity" which results from "the process of harmonising self-definition and role-expectations". This leads to the emergence of a new self, and the dissolution of the prior self, through reconstructive measures via change "in new, creative ways" albeit the painful memories of the prior self never fully disappears (Johnson and Ferraro 1984:121). The steps before internalisation are the objectivation and habitualisation state, whereby newer members like Aprilyn retain the meaningful influences by others and actuate it such that they become "routines in their general stock of knowledge", which become taken-for-granted and easily accessible for future projects (Berger and Luckmann 1966:71).

The above evidence; however, cannot provide exhaustive evidence on whether or not this gradual shift to internalisation is stable. While content analysis alone, without the assistance of direct interviews, may not firmly establish this stability, I have obtained some biographic evidence by tracing Aprilyn's posts in the following six months after the above-studied message. In September 2012, she wrote:

"Last time I was there it just made me sad and terrified [...] I felt marooned from everything "before BC". I thought I might always feel that way, but now my life is connecting itself back together into one whole."

Later, as October approached, she wrote:

"For me with my situation I know that the harder I try to not think about the worst case possibily, the more it will keep popping up [...] avoiding the negative just doesn't work well for me. Instead I am trying to make peace with the negatives. [...] But death is part of life [...] Just trying to look [at] the worst case as clearly as I can and see that it might not be so intolerable, yet without assuming that worst case is going to happen."

By suggesting that she is trying to "make peace with the negatives" because doing the opposite does not work, Aprilyn is slowly accepting the idea that death is an integral part of life while understanding that the "worst case[s]" brought about by cancer may not be as intolerable. While my methodology cannot trace the plethora of other external events affecting her, her affirmations at page 64, coupled by the above evidences, may suggest this to some extent, which will ultimately lead to externalisation, in the fourth stage of my developmental model.

In reading the exact quotations of these patients, I am able to get a glimpse into the mental states of these patients, in moving from their original fatalism into one whereby every moment seemed to count in the grand teleology of meaningful existence. Indeed, patients in studies of online cancer support groups eventually moved towards a greater peace by accepting

the "limits of their ability to control the circumstances in their lives" (Halstead 2001:1541). To provide more evidence in showing how social influence facilitates this cancer-coping growth, I present Willow, who wrote on May 2012 in a thread involving avoiding the thought that one's life has been ruined:

"You somehow emerge from the ashes. Still you, but a 'you' is that is unrecognisable to yourself. [...] Each day a 'fragment' of post-cancer 'you' will become apparent. Those fragments, the broken bits, we have to put them back together somehow. [...] Also, the women here, when I felt I could not cope they helped, soothed, dried my tears and lit the way for me. I gratefully followed."

Willow was diagnosed with stage IIIA breast cancer only 3 months before posting that message. Her message showed a transition in which she was slowly recollecting her lost selves, and emphasized the importance of how others on the forum "lit the way" for her. In a way, what does not kill one makes one stronger. Endorsing a being-for-itself attitude means to recollect oneself through a renewed temerity towards living. But to some patients, recollection was not enough - the *re-emergence* of oneself "from the ashes", in leading to a more contemplative one can occur from post-traumatic growth by "gratefully follow[-ing]" the advice and aid of more experienced women on the forum towards this step rather than purely from one's own self-realisation.

EXTERNALISING A BEING-FOR-ITSELF MENTALITY

I remind the reader about Christine, who remarked on Feb 2012: "[...] A part of me just wants to forget the whole thing and just move on with life, and not get any treatment[...]" on a prior-analysed thread on finding acceptance (ibid page 86). After internalising the being-for-itself values in the previous section, some veteran members eventually externalise them onto others.

Christine posted this 2 weeks after diagnosis with stage IIA IDC. This implies an evasive perspective through ‘forgetting’ where Christine was reluctant to face the contingencies and actualities of her illness by letting things “move on” as it is and succumb to the fate of no treatment. On top of the others whom I have quoted earlier, Christine was also in turn responded to by Celeste in February 2012, an experienced member of the forum who had posted more than several thousand messages and has been ahead of Christine in terms of treatment:

Before I show Celeste's response to Christine, I traced Celeste's history and found her following posts. On September 2009, one month after diagnosis, she wrote in a thread of ranting about her feelings, where she sought encouragement and advice from other senior members, in a presumably realisation or influence stage.

"I haven't been feeling much anxiety over this, at least, not after the initial diagnosis. I repeat that so often I'm beginning to wonder if it's true! I'm feeling a certain extent now, because I've [...] finding it hard to do anything."

By saying that she was "beginning to wonder if it is true", she contradicts her first sentence. This was followed by her affirmation that it was the case to a "certain extent" by finding it "hard to do anything", therefore, showing that she seemed to have not fully internalised a being-for-itself attitude. However, she continued writing in the same thread a few days later:

"I have to remember to get up and out no matter how bad I physically feel. It really does do some good."

She also wrote on October 2009 in the same thread:

"[...] this is going to be a big loss for me. I will get over it and go on, as we all have to. I think my recovery will be easier if I have some sort of mound straight away but if I can't, I won't get suicidal or anything."

By desiring a 'mound', it suggests a certain ambivalence to proceed with life, preferring it to end "straight away". Nevertheless, this negativity was reframed by saying that she would "get over it and move on", "no matter how bad [she] physically feel[s]" and not get "suicidal", implying a slow transition towards internalising the temerity to not surrender to a being-in-itself passivity, but to move on with life.

Now, 3 years later, she replied to Christine:

"I have my moments in the middle of the night where I get fearful and mourn what I am going to lose, but I live my day-to-day live in a normal way [...]For me, the key is researching my disease and taking charge [...]. You can never get rid of thoughts of cancer but you can make sure you don't sit around and mope. [...] If you cry all the time and live in fear [...] it won't make cancer go away [...] You can choose to act strong [...]"

Celeste was diagnosed with breast cancer in Aug 2009, which worsened into stage IV 5 months later; however, by her own admission on her profile page, she is "now cancer-free" on Oct 2011, half a year before replying to Christine. As of conducting this study, she has 4649 posts on the forum since she joined on August 2009, and in perusing her threads and posts, she regularly shares her experiences despite being cured, and encourages and counsels new cancer patients. Thus by 2 conditions: experience and wisdom, she is an "experienced" cancer survivor. The evidence above shows that she has progressed from the realisation to the externalisation stage, rather than simply anchor herself in the final stage from initial diagnosis.

Celeste's case suggests that not all roles or individual social selves are equal in sustaining the social distribution of knowledge. Berger and Luckmann (1966:93) wrote, that "some roles however, symbolically represent that order in its totality more than others". It was to my observation of the thread that her words were replied to, and viewed in concordance by many other members as compared to the messages of 'newer' members - this may suggest that being a cancer survivor, her words seemed to carry more influential weight than inexperienced members. She also served as a role through which she contributed to the formation of the "typifications of conduct" in the generalised "common stock of knowledge" (p. 92). Berger and Luckmann

(1966:122) wrote, that "human existence is, ab initio, an ongoing externalisation" where individual subjectivity is implanted into reality. By objectivating her experience and coping style to others like Christine, Celeste becomes a carrier of her definition of reality, which is externalised to maintain the symbolic universe to this. All definitions are therefore "always embodied" - that is "concrete individuals and groups of individuals serve as definers of reality" (p. 134). Therefore, the roots of all externalisation and the symbolic universe comes, concretely, from people like Celeste through the dialectic of socialisation and interaction.

As Clark (2002:172) found, in her research of sympathy, "in all human interactions, social actors create, evaluate, and negotiate microhierarchy". On the forum, 'gate-keepers' like Celeste were ranked higher by users on the basis of their experience, while those in a developmental stage beyond existing users were seen as holders of wisdom and understanding. This 'ranking' is constantly "in flux, and can change in an instant" (Clark 1997, 2002).

Celeste continued to mention in the same post above:

"Now, I know there are people who suffer from chemical depression and they can't change their mindset but this note is directed to a normal person who has suffered a serious setback, like most of us."

This alludes to the peripheral mental and physical obstacles that may impede a full internalisation and externalisation of a being-for-itself mentality. While the above studied thread suggested a trajectory of existential recovery, I decided to find contrary evidences for a more

balanced scientific examination. On searching the forums for "chemical depression", I found another thread involving the peripheral experiences of cancer-coping in real life, where I found that one limitation of my proposed four-stage model was the exclusion of certain physical and neuro-chemical barriers in the developmental process - agents were assumed to crisis-ridden but simultaneously sober in their mental processes. In this thread, Gina wrote poignantly, that "there is a solid link of a chemical imbalance in the brain, not just a matter of "get over it"!!!!", and she had been on anti-depressants for 25 years. In a follow-up post, Whitney also averred that she herself required "bioidentical hormones" due to her "lack of estrogen" in contributing to her fatigue and lack of enthusiasm in life. Some users, like Gina, resorted to the use of benzodiazepines like Xanax, or anxiolytics like Prozac to cope due to the lack of chemical balance in their brains. While this helped members like Gina to cope, for others, like Rae, wrote:

"[...] How friggin' depressing is that???? I don't think the Cymbalta was giving me what the Zoloft and Wellbutrin were. So we add Seroquel which is an anti-psychotic and fairly new. So I'll be a guinea pig."

Being prescribed medications such as Cymbalta, Wellbutrin, Zoloft, and Cymbalta made her feel like "a guinea pig", and she later said that it ironically induced "intensely sad dreams" and mood for her. Another, like Macy, "had to cope with depression [her] entire lifetime", suggesting a pre-cancer morbidity that exacerbated their abilities to maintain the lucidity to grow through the four stages.

Besides mental illness, physical fatigue was another barrier that impeded progression. Ariel again wrote, that "it was really frustrating to [her]- not being able to just WILL [herself] into being able to hike longer days" and that she ran out of breath easily from cancer. There is some truism, therefore, to the old adage, that "the will is strong, but the flesh is weak." Here, Joxanne, wrote:

"I am not the same person I was before BC...I blame part of the problem on the AI's.....side effects include depression, anxiety, insomnia, heartburn, joint pain, mental foginess, memory problems, no libido and the list goes on....it has affected my relationship with my husband...I no longer work full-time [...]"

Others, like Rosella, suffered from the "swelling in the tendons" and "Ehlers-Danlos Syndrome". Several members also suffered from post-traumatic stress disorder. Altogether, physical and mental problems shared by many patients contributed to the complexity of circumstances which cannot be easily subsumed under my four-stage model.

For Merleau-Ponty, the body is the "measurement of the world" and is the "primary source [of all] meanings" (Fontana and van der Water 1977). Physical pain and fatigue play a crucial role in initiating the crises in the realisation stage of my model. Charmaz (1995:657) Illness disturbs a person's "sense of wholeness of body and self" by intruding upon a person's daily life (Charmaz 1995:657) and by overwriting all other concerns (Cobin and Straus 1987). Some individuals never adapt to physical impairments, while others only adapt to it long after suffering losses (Albrecht 1992; Herlic 1973). This all-consuming bodily pain that concerns

patients like Ariel and Rosella may therefore be another precedent existential motivator, other than Schutz's "fundamental anxiety" or Heidegger's being-toward-death, in the realisation phase that thrusts one into seeking help on the forum.

Most importantly, these evidences suggest that the cancer growth process, while being believed to have a growth trajectory by many patients, is acknowledged that it is one which is far less pure - involving many physical barriers that complicate recovery.

Another additional insight discovered was that everyone goes through cancer differently, and may not be narrowly subsumed under my proposed model's trajectories. Queenie then mentioned, followed the previous quotes, that:

"not all women feel the same about losing their breasts, and [she] may be in a different place emotionally a year from now".

Following the metaphor of the Heraclitean river, being positive at one's current moment does not mean that they were impervious towards regressing to an earlier state - the threat of recurrence may dislodge a person in the externalisation phases of the model, back to the pensive realisation phase. Sonya also responded, that despite losing her canine companion, she was "not one to get depressed easily", suggesting that individual variation in personalities may either alleviate or impede movement through the various cancer-coping stages.

On the brighter side, there were those, like Penny, who was resilient, and threw "pink parties" (representing cancer) where her hair was shaved, but diametrically, Kristi talked about "getting stuck", while Sally, who was cured from cancer, wished "the cancer was back [so as to] have something to feel bad about!" - by having cancer, she could shift the blame of losing her job, her "deep sadness", and "lots of bad history in [her] family" to the anathema of illness, in hopes of exonerating her responsibility. Here I cite Kristi's quote:

"With the same treatment, some walk away with no side effects and their lives largely uninterrupted, while others are devastated. We do not know the fate of each other."

Others, like Maya, who despite being cured, "could [not] just shake [her] depression". This suggests that some patients never truly reach or anchor themselves permanently in the internalisation or externalisation stages of manifesting existential positivity, implying that my model's four-stages are not universalisable to all cancer patients - some get 'stuck', some regress, but those blessed with greater fortitude or resources are catapulted through the stages with greater expediency. Glaser and Strauss (1984) derived different trajectories of illness-coping. Reed & Corner (1984) further developed these pathways, suggesting that different people go through varying stages. Some transition into an easy trajectory, accompanied by little disease spread, high physical functionality, and a relative lack of degeneration. Others described a "roller-coaster" trajectory with alternating degrees of well-being and crises (p. 6). Lastly, there were those with rapid, aggressive and certain degeneration till death, with little respite. These varying individual trajectories was difficult to examine given the limitations of my methodology - it is possible that those with an "easier" trajectory may not experience sufficient crises that may

launch them past the realisation phase, while those of an "aggressive" pathway may perish before reaching the externalisation stages. Likewise, recurrence may cause one to regress into the earlier stages.

My additional examination of the above threads has shown that life is not about mutually exclusive stages. The four-stage classification described in this thesis is a simplified description of the actual processes covered thus far. As Mead (1938) pointed out, we ourselves are dialogues between "I" and "Me". While patients may internalise meanings from the "generalised other", and while Mead developed the concept of stages, his theory does not preclude future negotiation with the self. The different trajectories of Maya and Penny show that some patients may renegotiate with the self - regressing to an earlier stage, instead of being permanently shifted in the later stages of my four-stage model.

INTERNALISING THE EMBRACE OF ONE'S BEING-IN-SITUATION

I found some expressions of an embrace of one's being-in-situation towards cancer. A member, Jeanette expressed her fortitude and confrontation of such to everyone on September 2009, in a thread involving wanting more than just the present:

"Today I went to the beach [...] We played ball, walked along the shoreline [...]The weather was perfect, [...]. And I said to myself, "what a great day!" Then all I could think of was wanting more. And more. [...] I can't tell you how good that feels. But soon that will

change. [...] But I keep worrying about the limited supply. How do you enjoy today and leave tomorrow out of the picture?"

In Kotarba's (1983) study of chronic pain victims, formulating meaning is a necessary step to break the vicious cycle of pain caused by meaninglessness arising from the demoralisations of their disease. Meaninglessness can lead to a pleasurable sensation known as "experiential transcendence", which is an intense state of "extraordinary psychic unity and perceptual intensity" such that time and death both disappear (Lifton 1976:3-34). Jeanette's elevation to a state of wanting to fulfil one's possibilities represents this reconstruction of meaning against the meaninglessness of one's cancer.

That fact that Jeanette still worries "about the limited supply" suggests that she is not fully anchored in post-traumatic cancer-coping self yet. Jeanette was diagnosed with stage I cancer in 1992, only to be re-diagnosed with recurrent stage IV bone cancer in 2005. A search of her posts at around September 2009 shows that she is transitioning between the social influence and into the internalisation phase. In the text above, she mentions that she now has the verve to embrace the in-the-present appreciation of life by enjoying and appreciating it. By "wanting more" and by thinking that her days "will change" for the better, she is presenting a forward-lookingness despite the uncertainty of her 'limited' days, instead of displaying hopelessness and languidness, suggesting a gradual internalisation of positive cancer-coping changes. This parallels van der Spek et al.'s (2013) paper, which explains that many cancer survivors gained resilience despite the ambivalence towards cancer, rather than yield to the negative side of their mixed feelings towards their future, in line with the availability of some fortitude and

hopefulness required to accept one's being-in-situation. However, Jeanette's last line shows that she is in a state of transition between the 2 stages, as she still seeks help and social influence from other more experienced members.

The above citation by Jeanette per se does not highlight the social influences that have predated her writing of her message. However, I have found evidence showing how such influences are instead an ongoing process that stretches into the internalisation stage. For instance, the following individuals responded to her: Elizabeth - "By taking a day at a time-it's all any of us can do!", Freyda - "Ditto. Just don't think about it. Live for today as the cliché says." - and finally, Nancy: "Treasure those great days, and live all of your other days to the fullest. You can't keep the worries of tomorrow, but don't let those worries take over your life. [...]"

Through consensus and encouragements, the transition to acceptance and a *carpe diem* attitude focused on the present is fostered rather than discouraged. Additionally, other cancer patients, like Catherine, who was simultaneously going through the same transformation, re-affirmed and provided grounding to Jeanette's similar transition, as found by Shaw et al. (2000: 148) by responding to her:

"I don't know the answer...sometimes I feel like I am drowning. [...] My priorities have shifted...something always has to go just so I can enjoy or do the smallest of things. I guess maybe that's the answer for me...finding joy in the small things, and being grateful for all I can still do instead of dwelling on what I can no longer do."

Catherine's occasional "drowning" shows she was not fully anchored in a new cancer-coping self yet, but her current search for "answers", such as "finding joy" entails a transitional internalisation stage. These responses may suggest the ongoing process of socialisation in which the approbations of others lend credit and support to one's own gradual transition in this stage. A more conclusive example of this change through time, from social influence, was from Lilith, who wrote the following account of her transformation in a brief auto-biography on Feb 2012. Here I re-quote Lilith, from the last chapter:

"I have been on this journey for 2 years. Initially I woke up every morning thinking it was all just a bad dream. [...] It has only been in the past week that I have begun to let go of much of my anger [...] Denial has been very strong in me since the beginning [...] I lost that early on, but resorted to using a military approach to get through treatment (Mission: Survive to Enjoy Life) [...] Hanging out here with strong women who have gone before me has been a Godsend."

The second line suggests a slow transition to an internalisation phase based on acceptance, while the last line suggests the role of influences from "strong women" on her. Berger and Luckmann (1966:84) wrote that once the "same body of knowledge [of cancer-coping] is transmitted to the next generation, it is learned as objective truth in the course of socialisation and thus internalised as subjective reality [which] in turn has the power to shape the individual". Lilith's account shows this transformation, where her personal biography becomes shared with other members and is incorporated into a common stock of cancer-coping knowledge through "intersubjective sedimentation", made possible by "reiterated objectification

of shared experiences", as evinced by her transmission of a newly-internalised ideals onto other members (p. 85). In a way, individuals are not born members of the cancer forum - they are born with "a predisposition towards sociality" and are "induced into participation in the societal dialectical" as described in the influence and internalisation stages of this study, to become socialised into experienced gate-keeping members of the forum through social camaraderie, rapport, and support (p. 149-150).

EXTERNALISING AN EMBRACE OF ONE'S BEING-IN-SITUATION

Following Aprilyn's and Miriam's interactions in the previous chapter (ibid page 63), Miriam wrote:

"On positive days, I just try to proceed with an understanding that I will live a long life, hence, continue to save money, go forward with that degree, enjoy my children...and count on being there for them. I do find myself being less scared to do things I have always wanted to do (maybe the seize the day part)."

Although Miriam was not cured from cancer, a search on her other posts in this timeframe has shown that she has developed many coping strategies and wisdom to deal with cancer through a positive *carpe diem* attitude. Using her treatment experience and coping strategies, Miriam re-orientes Aprilyn's original disconsolation and dejection towards assuming responsibility for her life and presented an alternate one based on eventual acceptance and hopefulness.

Externalisation is also shown in another thread involving feelings that one's life has been ruined, where Natalie, an experienced member, encourages Penelope, a stage III breast cancer patient, on Jan 2014:

"My scars have faded to fine white lines. [...] I'm up for anything now. Why not? I never ran before b/c but a few years ago I got into running, and now love running 5K and 10K races, and I even ran a half marathon last year! [...] If I don't recur, then all that time I spent worrying about recurrence was wasted. "

Natalie was diagnosed with stage IIB IDC on December 2007, and by her own admission, "I'm six years out now [from her cure via surgery] and loving life", and is therefore an 'experienced' cancer patient. The first line in the above quote also adds to this testimony. By exemplifying one's progression with the tested experience that time can prove curative and that worrying is pointless, Natalie presented an embrace of life by actively engaging in challenging activities such as marathons, which served as a counter-example which dispelled Penelope's resignation. She also affirmed that gradualism was necessary for existential regeneration - convalescence could not be rushed. Thus, this series of interactions emphasized how support groups provide "positive role models" (Grande, Myers and Sutton 2006:326) in contributing to coping and growth, and that sharing personal experiences also offers "insight into the choices and thought processes of a "similar" [cancer sufferer]" (Sillence 2013:483). Natalie thereby acted as a credible positive role model through experience for others to follow.

How do we know that Natalie has been through the earlier influence and internalisation stages? Here, I traced her to a June 2008 thread on whether life will be the same, where she wrote:

"[...] Now I can start to rebuild my life again. Next week I start to work out, even if I have to start at a level that seems ridiculously low to me compared to where I used to be. I'm starting a gentle yoga class Monday, and will go back to the workout room as well, even if all I can do now is maybe 10-15 slow minutes on a treadmill. It's good to know that if I keep working on it, a year from now I have a decent shot at feeling like my old self."

The above remarks shows that Natalie, 6 months after diagnosis, was proactively but slowly *starting* to "rebuild [her] life", albeit at a "ridiculously low" level, highlighting a shift towards internalising the gumption to remediate her symptoms. This was greatly facilitated by influences by others on the forum, as she wrote in June 2008, on a thread on growth:

"This website has been a real lifesaver for me in this journey. I honestly don't know what I would have done without it. It has great info and these forums are filled with wonderful women who have been through and are going through what you are now. You are not alone as long as you have internet access [...]"

Therefore, Natalie has previously been through both the influence and internalisation stages, while the above quote suggests the role of support of other "wonderful women" on the forums on her growth during the influence stage.

Erin further replies to Penelope on April 2014:

"A few things that have helped; Learn as much as you can about your situation, treatments, options, side effects etc. Don't be passive and wait for your medical team to tell you! [...] Feeling down, angry, hopeless etc. are par for the course as you navigate this. Let it flow, but don't let it take over your life."

Erin, at the time of posting was already 3 years into Stage IV cancer. She claimed in the same post that she "don't claim any great insight, other than the perspective that time has given [her]," therefore showing her experience with cancer. The worth of such words resided in their experientially tested formulae to cope with in life, personified within the spirit of experienced members such as Natalie and Erin, which provided a keen reminder that a bleak outlook does not necessarily entail a recourse to passivity. In an earlier study conducted by my supervisor and I, we (Williams & Goh 2015) found that patients eventually got back on their feet from the initial misery, and this was facilitated through consolation and the "rallied" help and redefinitions by others through online interactions. The motivation impact of Erin's words were shown, by Debbie's reply: "So as I read your stories [...] I can also understand the ones who are taking life and living it--making the best life has to offer. I am so thankful that no matter how we feel, there is somewhere to come (BCO) and get support, allowing us to see we are not alone and showing

us there is always someone willing to talk and listen." Whitney also added: "Reading this thread is especially helpful for me at a time when I am terribly distressed and simply feel that all the color is gone from my life."

I traced Erin's history to 2010, where she wrote, in a thread about just being diagnosed with cancer then.

"[...] I keep trying to remind myself that I will hopefully be over the mountain NEXT Christmas. And although it is a huge mountain (surgery, chemo, and radiation), the path is well-trod (ask anyone here!)."

By "the path is well-trod" ("well-trod" meaning "travelled by others"), Erin was referring to the guidance on cancer-coping from the experiences of other forum members, in helping her to cross the "huge mountain". Her constant reminder of herself to cross this hurdle suggests a concerted effort to move past cancer, rather than stagnate. On August 2011, she wrote in a cancer-coping thread:

"For some, resilience in the face of adversity comes easily, for others it takes more practice and maturity but it is one of the most valuable things you can learn in life. Keep working on dealing with whatever life brings from a position of strength and knowledge (but yes, you certainly can have bad days!) and for goodness sakes, enjoy each moment, especially your wedding!"

By August 2011, the remark above suggests a possible movement towards having internalised the embrace of being-in-situation, through the "enjoy[-ment of] each moment". Therefore, the above quotes bring evidence towards the amelioration of Erin through the four-stages of development, rather than her simply being at the externalisation stage from the start. The fact that Erin and Natalie have credited the forums for assisting in their transformation relates to the long-term progression through the facilitation of growth from interactions, substantiating further, the cyclical reproduction of knowledge from which patients internalise cancer-coping norms, externalise them, and cause others to internalise and subsequently externalise them again.

Berger and Luckmann (1966:156) wrote that institutionalisation is not always irreversible - as seen here, some stocks of knowledge are occasionally questioned by members in the influence stages, like the numerous examples given in the last chapter. However, the established institution (defined by people like Erin), which the positive cancer-coping stocks of knowledge "claim authority over the individual, independently of [their] subjective meanings", challenges the negativities of people like Penelope from becoming a dominant part of the institutionalised order on the forum (p. 80).

The above findings that detail developmental growth have been buttressed by existential sociologists, who found that individuals first face "shame, anger, fear, powerlessness, and isolation" when faced with existential challenge, and then to progress towards internalising "feeling pride, confidence, and connection" (Johnson 2002:193), becoming integrated with a new social environment's stocks of knowledge and expertise, until one becomes a "developing

leader", who then guides others (McDaniel 2002:138), by externalising their new beliefs. To partake in this "externalising" role, Clark (2002:174) found that these guides, such as Natalie, have to enact a social role by establishing intersubjectivity and empathy to others, offer "socioemotional gifts such as respect and concern" while not expecting returns for one's nice conduct, or emphasize one's role selfishly. Learning this role is critical as it allows the passing on of knowledge to new, inexperienced cancer members. Schutz (1966) wrote that there are four kinds of social relations: contemporaries, those which we share the same historical period and general knowledge, consociates, those whom we are personally involved, predecessors and successors. Through the internalisation stage, predecessors and formed, like Natalie, who learn this social role, then pass on their knowledge through externalisation to successors like Debbie, which crystallises the existing stocks of knowledge.

The below diagram summarises the transition of the studied members from the earlier stages to the internalisation and externalisation stages, as discussed this chapter:

Developmental History of Studied Members

Name	Realisation Stage	Influence Stage	Internalisation Stage	Externalisation Stages
Natalie	Never ran a marathon before	Wonderful women on this website has helped me in this journey	Starting to rebuild life slowly again	Living a loving life; marathons; Scars faded
Willow	Was 'broken bits'	Gratefully followed advice from others	Slowly emerged from ashes	
Aprilyn	Too much energy to hope for the best	Find all these wonderful stories and support	Initial panic has passed; life is reconnecting; making peace with	

			the negatives	
Celeste	Had moments at night where I get fearful; finding it hard to do anything		Won't get suicidal; will try to get over it	Now I live my life in a normal way
Catherine			Priorities have shifted; enjoy smallest of things	
Lilith	Woke up everyday think it was a bad dream			I have let go of my anger
Erin		The path is well-trod	Can cross the 'mountain'	Enjoy each moment
Jeanette			Still worry about limited supply; Enjoying ball, beach, life momentarily	

The study above only examined the socio-interactional aspects of cancer patients within the context of the forum. The interactions of Erin, Natalie, and Debbie showed how cancer patients coached each other towards growth. However, the broad spectrum of human relations permeating across other familial and organisational dimensions were not available to me and thus are beyond the bounds of this study. The otherwise linear track of development in this study was complicated by the ways in which cancer has diffused into the social lifeworld. I found this important to report, for in the same thread (on Erin's reply to Penelope), Daisy wrote that during her cancer journey, her parents died, flooding her with "fears and worries":

"After my parents died [...] you lose your footing on earth and that was exactly how I felt.

I know as we all get older, we will lose more and family and friends that we love and

now with BC it just makes it all closer and a lot more frightening besides having to deal with the loss"

Kami also paralleled this, writing that during her treatment, her best friend and dog passed away, necessitating being put on Celexa to "move forward with [her] grief". As she wrote, that "time, memories, and patience with [themselves]" are also required to get through such bereavements. The loss of companions results in both emotional grief and a withdrawal of social support, which complicates the trajectory of post-traumatic growth, necessitating more than just individual spiritual fortitude to get through. More broadly, there were undoubtedly a wide variety of people and events in these women's everyday lives, outside the internet forum, that impacted their existential sense of self, which were not available to me.

Social barriers further complicate growth and coping. In the same thread, Kristi mentioned that "new relationships are tricky" due to the potential stigma brought about by revealing one's cancer predicament. This was comported by Wendy, whose family viewed her with stigma:

"My family behaved like it was contagious. My sister particularly was now I was touched by cancer and she hung around with me then somehow she would get it [...] she ran off to hear GP the day after my dx asked for an emergency appointment to get herself checked. [...] I waited for her to show up as we had agreed. She didn't. I phoned her and she said she 'couldn't face it'"

Stigma aside, poor social resources, such as the offer of face-to-face cancer support groups may not be lucrative - Vicky wrote of her extreme shyness and taciturn demeanor in having been to two face-to-face cancer support groups. Being "hard able to speak" and incapable of affording counselling due to financial difficulties reduced the effectiveness of interventions. Kristi argued with Vicky about the limitations of such groups, due to the lack of anonymity and directness of meeting other similar individuals. Marilyn wrote, in particular, of someone in such a group who "spoke to [her] in such a smug and condescending way that [she] only had to have a lumpectomy and that" Marilyn's case being far worse was reassuring to this person. The vulnerability of these patients were met with insensitivity from others, through faux pas, such as being "handed a bag of boob shaped pasta", or having a surgeon mentioned "save the big guys for next time." Altogether, many forum users agreed on the way in which society poorly handles cancer patients.

Therefore, intruding life circumstances like bereavement and the inadequacy of social resources complicate post-traumatic recovery in a way that personal strength and online support alone may not facilitate cancer-coping transformation. Such obstacles thus impede development towards the internalisation and externalisation stages. The chart below shows the types of barriers faced by the studied forum users throughout this chapter:

Barriers Faced by Studied Forum Users

Name	Description of Problem	Type of barrier
Rae	Drugs made me feel like a guinea pig	Mental
Macy	Coped with depression my whole life	Mental and Individual fortitude
Gina	On anti-depressant for 25 years	Mental
Gina	Used benzodiazepines to cope	Mental
Joxanne	Suffering from side effects of drugs - depression, fatigue etc.	Mental and Physical
Rosella	Swelling in the tendons	Physical
Kristi	Lost job, sadness, bad familial history; relationship issues	Relational
Maya	Could not shake depression	Mental and Individual fortitude
Kami	Being put on Celexa	Mental
Marilyn	Condescension from others	Relational
Vicky	Shyness in face-to-face cancer support	Relational
Penny	Threw pink parties	Individual fortitude

RELATION OF THE FINDINGS TO THE RESEARCH QUESTIONS

Now we are in a position to address the second and third research questions of this thesis:

(2) "What are the social processes through which people's cancer-coping beliefs and practices are transformed via social interactions with more experienced forum members?"

(3) "How do patients move away from their initial "life crisis" and then transmit what they have learned to others?"

Initially, it is the propinquity to death that presents an inner psychological impulse for cancer patients to preserve their existence, which serves as an intrinsic drive for them to seek help on the forum. Initially, new forum users were unsure of their cancer outcome when they first enter the forum. They enter the realisation phase and experience painful meaninglessness from being the "victim of external, harmful forces, which destroy the security of the self (Kotarba 1984:227). The realisation phase made victims realise the harsh actuality of potential annihilation and powerlessness.

They then enter a fraternity of like-minded people, in the influence stage, with the same goals and analytical concepts, where one is identified with "a world of shared experience" (Patrick and Bignall 1984:214). This influence stage involves interacting participants developing a stock of knowledge of mutual expectation of each other's roles and duties through identification with each other's similarities, which then allow a "reciprocal process of acting toward and reacting to the other interactant, creating in the process, the interaction self" (Henderson 2002:237-245). The 'interactional self' in the influence stage is thus always a

confluence between how others sees one's actions towards the other, which produces stability and predictability in the relationship, just like on the cancer forums. The influence stage encompasses counter-definitions, refutations and contestations of negativity, using the 5 positive cancer-coping stocks of knowledge held by senior members, which compel the patient to question her own negative beliefs, while being opened to positive cancer-coping ones. These objectivations then compel the latter to question their own initial pessimistic worldviews, and through time, internalise the new stock pools of knowledge, by rejecting the old existential self based on dread and hopelessness. Encouragements and rapport in the influence stage assists and eases this transition to a more permanent externalisation stage.

Finally, after months of years of stable internalisations, some of these initial nascent members transform into experienced ones, who then repropagate the cycle by externalising new social forms, consisting of the 5 positive cancer-coping stocks of knowledge, onto new inexperienced members, granting the latter a "new basis for perceiving uncertain social conditions" (Kotarba 1984:229). Altogether, this chapter relates to the second theme of existential sociology in my literature review (ibid page 23), where the self grows from crises, through the 4 stages described in this thesis, towards an embrace of their being-in-situation and being-for-itself in themselves.

My research also shows, in relation to the third theme of existential sociology (ibid page 27), that the existential self is reflexive, becoming, and is a source of tension between individual and society (Kotarba and Johnson 2002). The self is continuously in the process of flux and becoming through "complex involvements in role play" with society (Douglas 1977:66). Born of

a "natural attitude" towards social gregariousness (Schutz 1966), the existential cancer self goes through the 4 stages developed in this thesis, where social influences facilitate cancer-coping growth. Thus, this model shows a sociological and interactional basis that underpins existential growth, seeing it as something that is not endogenous, but can also be exogenous and facilitated through social interactions.

Also, we are now in a position to clearly answer the first research question:

(1) "Do the studied cancer patients follow a developmental pathway from negativity to positivity during their time on the forum?"

Altogether, my evidences in this chapter and the previous chapter both suggest that there is a general momentum from the realisation to externalisation stages; however, physical, social, intrapersonal, financial, and material barriers further complicate the four-stage process of cancer-coping. Additionally, instead of assuming a linear and progressive developmental track, some patients stagnate in the realisation and influence phases, unable to progress, due to physical and mental illnesses. Some may even regress to an earlier stage, while some cope through redefinition of their physical bodies, rather than merely of existential states - an axis not considered in my deductive model. This model provides a greater closure, in suggesting that each patient goes through the developmental stages differently, due to a combination of individual and societal obstacles.

Conclusion

Chapter 7

So far, my study has suggested that existential sociology contributes to the mainstream corpus of sociological thought by asserting that the existential self must be studied, with all its feelings and thoughts. It also found that the cancer-coping self is embedded in a broader social reality that influences its development. Therefore, growth is dialectical inasmuch as it is social. Here, I establish four main practical implications and conclusions of my study, and discuss its limitations.

1) EXISTENTIAL PHILOSOPHY AND SOCIOLOGY EXPAND UPON SOCIOLOGY THROUGH THE INCLUSION OF INNER THOUGHTS, FEELINGS AND EXISTENTIAL STATES

The works of earlier sociologists, such as Max Weber and Durkheim are limited by the use of *external* taken-for-granted abstractions such as "norms", "role", "belief" and "class" onto the objects of study (Berger and Pullberg 1965). As discussed in the literature review section, existential sociologists have suggested that human beings have to be studied holistically, by paying attention to their feelings and thoughts. As seen in the realisation phase of my study, humans are a highly "internally-oriented [and] privatized animal" with emotions of dread, fear, avariciousness, love, concern, trust, despair, hope, and joy, which forms the fundamental substratum of society (Manning 1973:209). From facing one's Heideggerian being-toward-death, one is surrounded by negative and strong emotions that compel one to seek help, question their

life, and reconstruct a new self. Therefore, these *inner* feelings are a primary and foundational source of social knowledge that cannot be ignored, for they undergird social action (Cooley 1926; Roszak 1969).

As shown in my influence and internalisation/externalisation chapters, the works of Sartre further expand upon the latter two, by introducing existential categories such as being-in-situation and being-for-itself. My studied patients evolved from confronting their Heideggerian being-toward-death by proactively questioning their life's axioms, and worked towards what authentically gives them joy and fulfillment given their potentially limited time. The works of Weber and Durkheim discarded the volitional aspect of social action, by reducing it to sociological determinism and abstract, taken-for-granted properties, such as class and gender, which ignores this introspective philosophical questioning within agents (Manning 1973; Douglas 1970b). Ultimately, the internal life-world of patients comprises of inter-subjective experiences that cannot be mathematicised or objectised in the manner of the physical world (Schutz 1962). The influence section has shown how positive cancer-coping stocks of knowledge arise through a dialectical interaction of one's internal existential life-world with others, involving both intrapersonal questioning and influences from others, which leads to the formation of these stocks, rather than assume that they are extant, immutable, and axiomatic. This was done through a meticulous description of the actual inner thought processes exchanged between patients, evinced in their writings, in line with the idea that the social sciences must study the first-order, existential, inter-, and intrapersonal constructs that undergird social reality rather than ignore it (Schutz 1962; Schutz 1972; Manning 1973).

2) THE CANCER SELF DOES NOT SIMPLY STAGNATE, BUT CAN EVOLVE THROUGH STAGES

In my literature review, Krumweide and Krumiede (2012), Burke & Sabiston (2012), Hamrin and Halldresdtti (1996), Jefferies and Clifford (2012), and Šprah and Šoštarič (2004) all suggested that cancer patients, upon diagnosis, enter much denial, worry, dread, frustration, fear, hopelessness, pessimism, and defeatism. Most of these studies do not proceed in conducting a follow-up of the evolutions that may follow from initial diagnosis, while some of them maintain that this negative state of being is static and does not ameliorate. This is at odds with Heideggerian or Sartrean thought that one should confront one's being-in-situation and being-for-itself through a change in one's perspective endogenously. The internalisation/externalisation chapter furthers research, by conversely showing that some patients eventually overcame their initial existential quagmire, by transitioning towards, and internalising positive cancer-coping beliefs and then actuating them physically.

My study has also developed a four-stage model of growth towards positive cancer-coping. This was done by incorporating the existential dimensions from existential sociologists such as such as Douglas (1984), Kotarba (1984), and Johnson and Ferraro (1984), into non-existential sociological findings (Wager 1999; Jefferies and Clifford 2012; Krumwiede and Krumwiede 2012; Burke and Sabiston 2012; Westman, Bergenmann and Andersson 2005) that studied the evolution towards positive existential stages of cancer-coping growth. According to most of the latter non-existential sociological studies, three general developmental, linear steps were charted: the first was a re-orientation in the experience of life through the re-questioning of

the worth of living. The second was a re-orientation to life caused by the physical distress of the illness. The third was a re-orientation to life through guilt, subsequent reflection, and ameliorations towards living life fully. My realisation and influence stages of my model parallel the first two stages, while the internalisation/externalisation stage parallels the third, but it also adds to extant literature through the incorporation of Heidegger's and Sartre's concepts, under (i) the movement from a being-in-itself to a being-for-itself mentality, and (ii) the transition from the evasion to the acceptance of one's being-in-situation.

The contribution of my model thereby provides a new and more discrete existential lens to analyse such growth, while building upon existing literature by suggesting that women with cancer go through dialectical processes of growth based on the resolution of paradoxes through a re-construction of one's life perspective across four stages, instead of merely stagnating.

3) THE INEVITABILITY OF THE EXISTENTIAL SELF'S INTERACTION AND EMBEDDMENT IN SOCIETY

The existential sociologist's role is not to delve into such metaphysics, but rather, to explain how the "taken-for-granted" reality is formed through social construction, in line with the sociology of knowledge (Berger and Luckmann 1966). No social organization may exist without considering its provenance from individual agents, for the beginning of all social reality occurs from individual consciousness. Existential sociology derives social order from the totality of ever-changing existential selves on the forum (Smith 1984). Undergirding this social reality is thereby an active existential self marked by an unyielding state of 'becoming', where participants

feed ever-morphing inputs to the organisation (Kotarba 1984:225-228). My thesis's main contribution to extant literature is to concretely show, using my studied online community, that, following Berger and Luckmann's (1966) social constructivism, there is an interpersonal process in which the social meanings of cancer-coping derive its essence through individual cancer patients, who constantly evolve and provide feedback to others, on the online support group.

This is shown in the realisation stage, that an initial crisis, such as the pain of cancer, compels people to cope by reconstructing a new self by confronting one's being-toward-death (Kotarba 1983). In the influence stage, patients objectivate the "nowness" of their individual existential perspectives into the social fabric, which is then challenged by the forum's positive cancer-coping stocks of knowledge, held by more experienced users. The prevalence of the more positive growth-oriented ones refutes the negative ones which facilitates the eventual internalisation of these ideas which constitute the stocks of knowledge by junior members. The positive cancer-coping stocks are transmitted by gate-keepers, but my study has shown that both the recipients and transmitters of social knowledge are not passive beings - they are active, self-reflective beings who may refute incoming suggestions. Not all individuals necessarily conform to the established stocks of knowledge, for this process is socio-dialectical, reflexive, and agential. Some choose to refute this, as shown by the influence stage, where I suggested that some patients regress rather than grow, while others internalise this objectivated knowledge by others, who then reproduce it through externalisation, in an ongoing dialectic which is then legitimated and institutionalised.

This thesis therefore contributes to extant literature, by suggesting that both structure and agency exist in a synchronistic manner on the forum. Although Berger and Luckmann (1966:151) wrote, that everyone is "born into an objective social structure which he encounters the significant others who are in charge of his socialisation". This social order is, however, the product of many individual selves, which objectivate a portion of their individual realities onto society, as shown by more experienced cancer patients on the forum. Hence, the existential self cannot be separated from the world, as it is fundamentally embedded in a broader social reality which it shapes, and is also sculpted by, in a dualistic manner.

4) OTHER PRACTICAL IMPLICATIONS OF THE STUDY

My study suggests that the richness of social interactions in support groups provide a powerful means of emotional support for patients. Recalling this thesis's literature review section, Zhao et al. (2013), Beaudoin and Tao (2007), Love et al. (2012), and Pinheri et al. (2008), all show that online cancer support forums provide a channel for cancer patients to vent their frustration, seek informational help, seek emotional and social support, and interact with similar others. This is rigorously demonstrated in my empirical chapters, where I found that online interaction allowed mutual exchanges to facilitate existential awareness, through a cyclical process, in which they benefit from, and in turn benefit other similar patients through validation and encouragement. Therefore, my thesis suggests that online cancer communities provide an alternative source of treatment beyond the biomedical paradigm of medicinal prescription, through the socio-interactional four-stage model whereby cancer patients can take

part in a broader social reality, in which their fortitude is shaped by others, and in turn, they gain the strength and temerity to cope with cancer, and then assist others on the community.

Next, my study highlighted the importance of introspection and philosophical questioning of one's internal, existential states in fostering growth. The core question in existential therapy involves how should exist in face of death, crises, or uncertainty. Practitioners who use existential counselling methods may therefore apply my findings to design a formulaic group-therapy treatment that may assist patients in growing towards positivity, perhaps, by 'modularising' the treatment into the four aforementioned stages, each with the three existential dimensions covered in my thesis, in order to guide cancer patients towards growth, by exposing them to interactions with other similar patients. The table below highlights my suggested treatment for each phase of group-therapy:

	Realisation	Influence	Internalisation	Externalisation
Being-in-itself/being-for-itself	Tackle reality that one is still a free agent	Expose patients to cancer survivors	Help patients realise that one can be empowered despite cancer	Help patients engage in activities of empowerment (helping others, teaching)
Being-in-situation	Tackle reality of the unchangeable nature of cancer	Expose patients to cancer survivors	Help patients realise that while reality is unchangeable, what they do with it is mutable	Help patients engage in activities that bring forth their potential (mountaineering, writing)
Being-as-actuality/Being-as-possibility	Tackle reality of being-onto-death	Expose patients to cancer survivors	Help patients realise that one can lead life meaningfully despite possible death, in one's remaining time	Help patients engage in activities that make the best use of one's life (marathons, coaching others, artistic works)

For patients in the realisation phase, philosophical questioning that involves a "dialectical debate" between one's reality of cancer (such as death, loss of freedom, meaninglessness, and aloneness) and one's empowerment as an existential being (Deurzen 1999:1), could be employed to help patients face immediate and important existential concerns. Patients in the influence stage should be exposed to similar others in group-therapy to "question [their] own lives" and "recognise [...] anxieties and doubts about meaning" (Frankl 1956; Szasz 1961). Next, to help patients move to the internalisation and externalisation phases, therapists must help them overcome "existential guilt, angst and anxiety" and to help them realise authentic values (Deurzen 1999:5). The key is to help patients realise that being-onto-death and the "fundamental

anxiety" are normal and inevitable, but what they do with their remaining life is largely a choice, slowly and procedurally.

5) LIMITATIONS OF THE STUDY

While the study does substantiate each of the causal pathways using varied examples, it is admitted that it faces several limitations: First, it lacks triangulation, whereby, due to sensitive ethical concerns limiting the capacity to directly interview these cancer patients, it was difficult to gather direct evidence that connects the actual existential phenomenologies of these patients with their inferred actions. Additionally, some of the existential explorations were inferred from my personal immersion within their network. Next, the purposive sampling method used may not be indicative of a broader and more representative sampling of more general trends in the forum. Future researchers could apply stratified sampling to the same dataset to either confirm or disconfirm my findings.

There are also limits to existential sociology. Crossley (1996:95-98) pointed out that existential sociology over-focuses on the individual, while de-considering "relationships, practices, and processes viewed from the trans-individual position of the systems which they form". Next, it fails to explore deeper, the relationship between the existential and bodily/biological aspects of cancer, in that it takes for granted the latter's role in one's existential condition (ibid page 112). Since the current socio-demographic profile comprised women breast-cancer patients, it is not known how variations in the type of cancer, age, nationality, and the stage of the illness trajectories may play a role in their various significances. Deeper, prospective

analyses may include a comparison with actual face-to-face support groups to study its difference to online ones.

Other limitations of this study involve the disadvantages of internet research. For instance, Lee (2000) and Jones (1999) commented that it provides only a partial perspective of the multifarious nature of the social world. Since researchers do not meet the users face-to-face, this leads to the loss of many layers of meaning, such as facial expressions or body language (Sade-Beck 2004). The time gap between thought and writing also adds a qualitative difference to speaking. Simultaneously, it is difficult to make clear distinctions between online and offline dynamics, and examine the lifeworld of people while offline (Varis 2014). Future researchers may therefore wish to address these issues in prospective studies for a more holistic and triangulated view of my studied topic.

SUMMARY

So far, I have set out to investigate how social interactions impact cancer-coping in cancer patients on an online cancer forum through the content analysis of their forum threads and replies. Instead of finding evidence that growth towards cancer-coping is endogenous and strictly intrinsic, I have found that social interactions provided emotional, spiritual, and informational support, rapport, encouragements, and camaraderie that have uplifted newly-diagnosed patients through a four-stage model of existential growth. This thesis is the story of how interactions impact cancer-coping beliefs. The final 4-stage model, developed in this thesis, is shown in Appendix B.

Ultimately, there exists a general direction of growth towards positive cancer-coping beliefs through an existential lens. The existential self is also constantly influenced by the social world that it is embedded in: it evolves through influences from the latter. The existential self cannot exclude the importance of its inner sanctum of thoughts, feelings, and emotions - all aspects must be considered holistically for there to be an accurate portrayal of both intrapersonal and social reality.

Glossary

Ductal carcinoma in Situ (DCIS)

Otherwise known as stage 0 breast cancer, where abnormal cells have been found in the breast milk duct's lining, but has not spread outside of the ducts or the surrounding tissue.

Embolization

A minimally invasive treatment that occludes, or blocks, one or more blood vessels or vascular channels of abnormalities.

Grade

Tumors are graded as 1, 2, 3, or 4, depending on the amount of abnormality.

Infiltrating/Invasive Ductal Carcinoma (IDC)

Invasive means that the cancer has spread to the surrounding breast tissues. Ductal means that the cancer began in the milk ducts of the breast. Carcinoma means any cancer that begins in the skin or tissues which cover internal organs.

Liver Resection

The surgical removal of part of the liver.

Neoadjuvant Chemotherapy

Medicines which are administered before surgery for the treatment of breast cancer to shrink the tumor and give one more surgical options.

Recurrent/Metastatic Cancer

Cancer that has spread from the place where it first originated to another place in the body.

SIR-spheres

SIR-Spheres Y-90 resin microspheres are microscopic resin beads that contain the radioactive isotope Yttrium-90 (Y-90) and emit radiation to kill cancer cells.

Stage I Breast Cancer

Cancer is evident, but it is contained only to the area where the first abnormal cells began to develop. Stage 1A means that the tumor is smaller than 2cm and has not spread to the lymph nodes. Stage 1B means that the lymph nodes have cancer evidence with small clusters of cells between 0.2mm to 2.0mm.

Stage II Breast Cancer

Stage 2 means the breast cancer is growing, but it is still contained in the breast or growth has only extended to the nearby lymph nodes. This stage is divided into groups: Stage 2A and Stage 2B. The difference is determined by the size of the tumor and whether the breast cancer has spread to the lymph nodes.

Stage III Breast Cancer

Stage 3 cancer means the breast cancer has extended to beyond the immediate region of the tumor and may have invaded nearby lymph nodes and muscles, but has not spread to distant organs. Although this stage is considered to be advanced, there are a growing number of effective treatment options. This stage is divided into three groups: Stage 3A, Stage 3B, and Stage 3C. The difference is determined by the size of the tumor and whether cancer has spread to the lymph nodes and surrounding tissue.

Stage IV Cancer

Stage 4 breast cancer means that the cancer has spread to other areas of the body, such as the brain, bones, lung and liver. This is often incurable.

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Appendix A

Actual examples of the analyses of thread messages

Table 1: Analysis of Being-in-itself and Being-for-itself

Original Thread		
<p>P said: "[...] That said, I feel like I'll be damaged goods forever and life as I knew it is ruined [...] There is damage to my career [...] This is so overwhelming. How do you from feeling like your life will be or has been ruined by this disease?"</p> <p>(Shows a <i>being-in-itself</i> orientation due to being overwhelmed and feeling that one is "damaged goods")</p>		
A makes the remarks below B approves or disapproves to the right	Signsof Explicit or Implicit Approval or Agreement	Signsof Explicit or Implicit Disapproval or Disagreement
1a) Stagnation in a <i>being-in-itself</i> orientation	<p>B said: "Yes, I feel like this has ruined my life."</p> <p>A said: "No words for the shock and distress. Then feelings of guilt [...] My suffer in silence & buck up mantra wore down, then crashed."</p>	<p>Posts that disagree with what P has said, but does not proactively endorse a being-for-itself orientation.</p>
1b) Shift to a <i>being-for-itself</i> orientation		<p>Y said: "You are clear not alone and you are not damaged goods. You did nothing to cause this so don't feel guilty. [...] Life will never be the same, but it can be very good."</p>

Table 2: Analysis of Being-in-situation

Original Thread		
Same thread by example P.		
A makes the remarks below B approves or disapproves to the right	<i>Signs</i> of Explicit or Implicit Approval or Agreement	<i>Signs</i> of Explicit or Implicit Disapproval or Disagreement
3a) Evading one's <i>being-in-situation</i>	A said: "[...] lots more ten years ahead of you. How long did it take you mentally to move forward...still struggle sometimes....[...]"	
3b) Confronting one's <i>being-in-situation</i>		Y said: "Lately I've been thinking about that a lot and trying to come up with a plan. I am trying to do mindfull meditation to help with the worry. I'm looking into Yoga to reduce stress."

Table 3: Analysis of "Chains of Interactions and Replies"

Original Thread		
Same thread by example P.		
A makes the remarks below B approves or disapproves to the right	<i>Signs of Approval</i>	<i>Signs of Disapproval</i>
3a) Evading one's <i>being-in-situation</i>		<p>A2 says: "I have had enough of this, I'm not going to put up with cancer any more"</p> <p>B2 says: "I feel that you should confront your issues with courage"</p>
3b) Confronting one's <i>being-in-situation</i>	<p>A1 says: "Cancer has taught me to be brave towards my issues"</p> <p>B1 says: "That's the right spirit. Let me share with you my positive experiences as well."</p> <p>C1 (replies to B1): "I agree, B1, that we should all be positive"</p>	

Appendix B

Figure 1: A Visual Representation of the Model Developed in this Thesis