

**RETURNING TO WORK: EXPLORING THE LIVED  
EXPERIENCE OF THE CANCER SURVIVOR**

by

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submitted in accordance with the requirements for the degree of

MASTER OF COMMERCE

in the subject

INDUSTRIAL AND ORGANISATIONAL PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

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OCTOBER 2015

## DECLARATION

I, Loraine Sonia Clur, student number 5934621, declare that “Returning to work: Exploring the lived experience of the cancer survivor” is my own work, and that all the sources that I have used or have quoted from have been indicated and acknowledged by means of complete references.



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LS Clur

October 2015

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Date

# ACKNOWLEDGEMENTS

I would like to express my gratitude to:

- above all, my Father in Heaven, for lifting me up when I felt discouraged and giving me the strength to persevere;
- my husband, Johann, for his support and for accommodating my study needs;
- my two sons, Dirk and Heinrich, who are also living with challenges ... I admire you both for your courage and perseverance. I am proud of both of you. Thank you for inspiring me in so many ways;
- my sister, Sally, who is a working cancer survivor, shared her experience with me and inspired me to choose this topic;
- Prof Barnard for her consistent feedback, guidance and encouragement;
- Prof Joubert for her appreciated positive contribution, motivation and advice;
- Barbara Bradley for the language editing of this dissertation;
- Huma Louw for her inputs with the analysis of the data;
- Jenny Seagreen for the final layout, formatting and technical editing of the dissertation and her valuable inputs in the completion of the study;
- and most of all, the participants who shared their experiences with me and made this study possible. I admire you for your courage and resilience.

## Heavy On My Heart

(Newkirk & Mann, 2005)

(The lyrics chronicle Anastacia's battle with breast cancer.)

*I try to fly away but it's impossible  
And every breath I take gives birth to deeper sighs  
And for a moment I am weak  
So it's hard for me to speak  
Even though we're underneath the same blue sky*

*If I could paint a picture of this melody  
It would be a violin without its strings  
And the canvas in my mind  
Sings the songs I left behind  
Like pretty flowers and a sunset*

*It's heavy on my heart  
I can't make it alone  
Heavy on my heart  
I can't find my way home  
Heavy on my heart  
So come and free me  
It's so heavy on my heart*

*I've had my share of pleasure  
And I've tasted pain  
I never thought that I would touch an angel's wings  
There's a journey in my eyes  
It's getting hard for me to hide  
Like the ocean at the sunrise*

*It's heavy on my heart  
I can't make it alone  
Heavy on my heart  
I can't find my way home  
Heavy on my heart  
So come and free me  
It's so heavy on my heart*

*Love, can you find me in the darkness, and love,  
Don't let me down  
There's a journey in my eyes  
It's getting hard for me to hide  
And I never thought I'd touch an angel's wings*

## **ABSTRACT**

The purpose of this hermeneutic phenomenology study was to explore and describe the meaning employees attribute to the lived experiences of returning to work after cancer treatment. Semi-structured interviews were held with eight participants and a thematic data analysis method was used. The results indicate that cancer survivors experience various challenges that make it difficult to function as they did before the diagnosis when they return to work. A critical hermeneutical reflection against the literature followed the structural analysis and resulted in a contextual framework that incorporated the individual and organisational perspective on the various influences involved in supporting cancer survivors to maintain their wellbeing when they return to work. Four phases, repression, comprehension, activation and reintegration, were identified when they tried to cope/adjust on their return to work. The corresponding forms of organisational support they expected through these phases were labelled motivation, information, navigation and stabilisation.

### **KEY WORDS**

Cancer survivor; employee wellness; hermeneutic phenomenological; lived experience; positive psychology; qualitative research; return to work; wellbeing.

## ACRONYMS

AIDS – Acquired immune deficiency syndrome

DDA – Disability Discrimination Act

DM – Disability management

EAP – Employee Assistance Programme

EEA – Employment Equity Act

GRR – Generalised resistance resources

GSE – Generalised Self-efficacy

HIV – Human immuno-deficiency virus

IOP – Industrial and Organisational psychology

LOC – Locus of control

LR – Learned resourcefulness

LRA – Labour Relations Act

OST – Organisational support theory

POS – Perceived organisational support

PTSD – Post-traumatic stress disorder

RTW – Return to work

SOC – Sense of coherence

SWB – Subjective wellbeing

TAG – Technical assistance guidelines

TTM – The Transtheoretical Model

VR – Vocational rehabilitation

WHO – World Health Organisation

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# CHAPTER 1

## RESEARCH CONTEXT AND RATIONALE

### 1.1 INTRODUCTION

The National Cancer Registry estimates that one in six men and one in eight women in South Africa will get cancer during their lives (Bhengu, 2012).

Cancer is a disease, but it also entails a series of psychosocial experiences that profoundly affect not only the person who has the cancer but many others in their work and personal contexts who are affected by and share these experiences. As such, the psychosocial effects of cancer are not an issue limited to the diagnosed individuals and their families, but extends into the workplace, becoming an important issue for employers and employees alike (Nowrouzi, Lightfoot, Cote & Watson, 2009).

Grunfeld, Rixon, Eaton and Cooper (2008) mention that early detection and diagnosis, as well as improved treatment, have led to a higher survival rate in all cancer types. This means that many cancer patients recover and can continue with their daily activities (Kennedy, Haslam, Munir & Pryce, 2006). From a social and economic perspective, work after a cancer diagnosis is in fact essential for some employees (Steiner, Cavender, Main & Bradley, 2004). However, treatment and side effects, as well as the psychological problems that the employee may have, are not always understood by the employer and colleagues (Messner & Vera, 2011). "It is important to understand the difficulties cancer survivors experience in order to develop interventions to better support them in their resumption of work" (Tamminga, De Boer, Verbeek & Frings-Dresen, 2012, p.144).

As suggested by Halidórsdóttir and Hamrin (1996), people need words to reflect on their experiences and to express these to others and thus come to an understanding and be able to move on. Such personal accounts will enhance understanding in the workplace and will initiate more appropriate action strategies to facilitate the reintegration and adjustment of the previously diagnosed employee in the work setting. The overall objective of this study was therefore to explore the lived experience of cancer survivors when they return to work (RTW) after cancer

treatment from a hermeneutic phenomenological perspective and by means of in-depth semi-structured interviews.

In this chapter I give the background and motivation for the study, as well as the reason why this phenomenon has been chosen; the relevant literature and research are reviewed; the problem statement, the research questions and objectives are given and the disciplinary context, meta-theory and meta-theoretical concepts are explained; the assumptions made in the study are given and then attention to ethical considerations, the potential contribution of the study, the thesis statement, definition of key terms and finally the chapter layout are given.

## **1.2 BACKGROUND AND MOTIVATION**

Choosing a particular topic to study is motivated by various reasons. In qualitative research, the researcher as the main research instrument (Terre Blanche, Durrheim & Painter, 2006, p.276), is challenged to present a transparent and authentic account of the aspects that motivated her to make decisions and choices throughout the research (Fossey, Harvey, McDermott & Davidson, 2002). From a scientific perspective, research should, however, be grounded in a defensible and solid theoretical argument directed by previous and current research trends (Bergh & Geldenhuys, 2013). Therefore, in this section I will first elaborate on how my personal reason for this enquiry evolved and then provide an analysis of the relevant literature and research, effecting a rationale for the study.

### **1.2.1 My reason for choosing this enquiry**

My inspiration for researching cancer patients re-entering the work context started when my sister discussed her RTW experience with me after she had completed her cancer treatment. She had breast cancer and had a bilateral mastectomy followed by reconstruction, chemotherapy and radiation therapy. She told me that because she looked fine, people expected her to be fine and to continue to work and live at a pace and in a manner she had always done. In reality she suffered daily from exhaustion and lymphedema<sup>1</sup> that affected her left arm. As a result she

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<sup>1</sup> Lymphedema is described as swelling that develops because of failure of lymph drainage (Harmer, 2011). Secondary lymphedema is caused by a build-up of lymph fluid in tissues after breast cancer surgery and radiotherapy. Lymphedema can result not only in physical discomfort and disfigurement, but also in substantial impairment of daily activities (Szuba & Rockson, 1998).

needed to rest more often when working on the computer. Personally she had to get used to and adjust to the fact that she was physically not the same as before. I could empathise with her, as I am also a cancer survivor and also had to adjust to living with the side effects of cancer treatment, which had a severe impact on me personally and on my work. Her story about RTW and the challenges she experienced personally triggered in me the realisation that cancer survivors do not speak about their challenges to colleagues and superiors in the work setting. I felt similarly misunderstood and very alone in coping with physical and emotional challenges when I returned to work.

In my journey with cancer I met numerous other people who were also living (and working) with cancer and we shared stories about unique challenges, especially in terms of returning to the work environment. I started to realise that there is a need to know more about this “profound and complex human life experience” called cancer survival (Pascal, 2010, p.1).

As I am consulting for organisations, I have to engage with employees and organisational behaviour, therefore my interest lies in industrial and organisational psychology (IOP). I decided to obtain and explore narratives from employees after cancer treatment with the purpose to gain insight in their experiences when they RTW. For the purpose of this study, I refer to the employee with cancer as the “cancer survivor” or the “cancer employee” and I will use these terms interchangeably.

### **1.2.2 Review of relevant literature and research**

RTW provides a sense of normality and control to the cancer survivor (Rasmussen & Elverdam, 2008) who experienced a sense of being “out of control” (Aldredge-Clanton, 1998, p.53) during the diagnosis and treatment of cancer.

According to Messner and Vera (2011), cancer affects survivors’ physical well-being and also has an impact on their psychosocial orientation. Although people may therefore be physically fit to re-enter the working environment, they face many psychosocial issues, including heightened emotions such as sadness, anxiety, fear, uncertainty, shame and other emotional concerns with which they may have to deal (Messner & Vera, 2011). These issues are induced by the physically demanding (and also often life-threatening) treatments for the illness

with permanent health impairment and sometimes debilitating effects even when there are no longer any signs of the disease (Adler & Page, 2008). According to Adler and Page (2008, p.30), “The emotional stress of living with a diagnosis of cancer and its treatment, fear of recurrence, and the distress imposed by living with the day-to-day physical problems ... can create new or worsen pre-existing psychological distress for people living with cancer, their families, and other ...” Some research suggests that cancer survivors find it difficult to return to work after cancer treatment, owing to work-related, disease and treatment-related or person-related factors (Spelten, Sprangers & Verbeek, 2002). According to Kennedy *et al.* (2006), there is a need for support, advice and accommodation from multiple sources to enable cancer survivors to reintegrate into a healthy and satisfying working life.

A preliminary literature review revealed the following as relevant to the employee with cancer when returning to work, which will be discussed next:

- Communication and support
- Factors that have an impact on work after cancer diagnosis
- Rehabilitation programmes/interventions.

#### *1.2.2.1 Communication and support*

Various role players are involved in the reintegration of the cancer survivor when they RTW, such as medical practitioners, occupational health practitioners, line managers and colleagues (Yarker, Munir, Bains, Kalawsky & Haslam, 2010). Communication and support between the different role players and between the work organisation and the cancer survivor in particular, play a significant role in facilitating an efficient and positive RTW experience (McKay, Knott & Delfabbro, 2013). In terms of communication and support to the cancer survivor, Amir and Brocky (2009) reported that a positive attitude from co-workers facilitated a more constructive and positive RTW for cancer survivors. Brannon and Feist (2004) furthermore mentioned that social support was important for the cancer survivor to maintain health after re-employment. Research has, however, indicated poor communication and support (Kennedy *et al.*, 2006) and emphasised a need for better guidance about how to relate to and manage the cancer survivor in the workplace (Amir & Brocky, 2009).

Amir and Brocky (2009) found that little work had been carried out to examine the role of professionals (e.g. oncology specialists, occupational health professionals and primary care providers) in the RTW process for cancer survivors. The limited research suggested considerable scope for improvement in this important area, as Amir and Brocky (2009) also found that survivors received very little advice from medical practitioners about their RTW. Similarly, Kennedy *et al.* (2006) mentioned that the cancer survivors in their study reported that they received little advice from professional health care people regarding work issues. Such a lack of established communication processes and guidelines contributes to the challenges managers and co-workers face when interacting with the cancer survivor. Cancer survivors can also participate in the communication process by being open about the challenges they experience and seeking information to facilitate a better RTW process (Pandey & Thomas, 2001).

Yarker *et al.* (2010) highlighted the problem of competence on the part of managers and co-workers to communicate with the cancer survivor. They found that line managers and colleagues were ill equipped to handle the needs of cancer survivors because they did not recognise or were not made aware of the long-term impact of cancer and its treatment on the individual. The difficulties that cancer survivors experienced were therefore not always understood by the employer (Messner & Vera, 2011; Tamminga, De Boer, Verbeek & Frings-Dresen, 2012) and this led to misunderstanding, poor communication and pre-conceived notions about the competence of the cancer survivor.

Shava (2011) in particular explored the challenges that the employer and employee face when the latter is undergoing active cancer treatment. Practically the cancer survivor sometimes has to be away from work for long periods to undergo treatment and the employer has to make alternative arrangements to ensure workflow. Shava (2011) found that such absences invariably created employee misconceptions. She highlighted the significance of not having preconceived ideas in this situation and concluded that the employer and employee should have the freedom to communicate their perceived challenges.

It therefore seems evident that lack of communication and information to and among the organisation, managers, health practitioners and cancer survivors

exaggerates the difficulties faced by cancer survivors when they RTW. Moreover, owing to ineffective communication, other significant role players in the process experience challenges in reintegrating the cancer survivor in a comfortable and efficient way. Communicating information to the cancer employee regarding his/her RTW and information to the employer on how to reintegrate and manage the cancer employee requires attention.

#### *1.2.2.2 Factors that have an impact on work after cancer diagnosis*

The treatment of cancer is physically very challenging to patients, requiring some combination of surgery, radiation or chemotherapy for months on end or even years. Adler and Page (2008) mentioned that even when treatment has been completed and no cancer remains, the frequently permanent serious residua of cancer and/or the side effects of chemotherapy, radiation, hormone therapy, surgery and other treatments can permanently impair cardiac, neurological, kidney, lung and other functions of the body, necessitating ongoing monitoring of cancer survivors' health. These residua and/or side effects have different complications and many challenging adjustments for different cancer survivors' daily living and as Amir and Brocky (2009) mentioned, will have an impact on their work decisions.

It seems as if the process of RTW is an important issue for many cancer survivors. Although cancer survivors feel emotionally better and welcome the return to normality, they also suffer trepidation related to disclosing their diagnosis to employers and co-workers. Treatment-induced physical impairments such as fatigue, general weakness, diminished physical capability, impaired cognitive functioning and loss of confidence are consistent concerns for many cancer survivors (Banning, 2011; Rasmussen & Elverdam, 2008; Shava, 2011; Steiner, Nowels & Main, 2010; Taskila, De Boer, van Dijk & Verbeek, 2011). Pullen (2013) mentioned that research showed that the ability to work effectively and be productive, for women with severe hot flushes, was affected. Mitchell and Bruen (2008) reported that "chemo brain" (cognitive impairment due to chemotherapy) led to a decline in the thinking process. Adler and Page (2008) reported on research done on women treated with chemotherapy for breast cancer that found subtle declines in their global cognitive functioning, most particularly in language skills, short-term memory and spatial abilities. Less impairment was found in their working and long-term memory and their speed of processing information. They

also reported on research that found similar varied cognitive impairments in adults treated for other types of cancers as well.

Another problem experienced by cancer survivors is post-traumatic stress disorder, which is a delayed psychological reaction to the cancer experience. A sense of loss and fear are common (Brannon & Feist, 2004). For cancer survivors, the fear of recurrence can result in persistent anxiety and difficulties in future planning (Lee-Jones, Humphris, Dixon & Hatcher, 1997). Studies have shown that in 30% to 40% of all types of cancers, pain is present. This means that either the disease (growth and progression) or the treatment causes pain for cancer patients (Brannon & Feist, 2004). These physical and psychological impairments can lead to psychosocial challenges, such as inability to work or fulfil other social roles (Adler & Page, 2008).

Physical symptoms are important predictors of work return and functioning (Feuerstein, 2009). In addition, factors facilitating work return of cancer survivors are a positive attitude from co-workers, the number of hours they are required to work and the nature of the work (Amir & Brocky, 2009). The cancer employee's level of qualification and the type of work also constitute factors associated with RTW. It has been found that cancer survivors with postgraduate qualifications are less likely to stop working and survivors from physically demanding occupations are less likely to be in employment (Amir & Brocky, 2009, Steiner *et al.*, 2008). In their review of 19 papers on cancer and work ability, Munir, Yarker and McDermott (2009) highlighted major concerns with employers' lack of understanding the long-lasting effects of cancer.

In summary, factors that affect cancer employees' RTW can be categorised into four main categories. Firstly, physical factors, which include physical impairments as a result of the disease, as well as treatment-related factors (side effects). Secondly, psychological factors such as self-confidence and anxiety that affect the employee's reintegration. Thirdly, psychosocial factors that are induced by the physical and psychological factors. Lastly factors in the work environment, including work and qualification requirements, as well as employer and peer support. Factors that should be considered in further research should therefore be approached from more than one perspective in order to gain a comprehensive orientation to the effective reintegration of the cancer employee.

### 1.2.2.3 Rehabilitation programmes/interventions

When cancer survivors have completed treatment, they have lost the safety net of active treatment and face challenges in resuming or altering former occupational and social roles. It is important that, in this period after the completion of cancer treatment, some kind of rehabilitation or intervention be put in place to assist cancer survivors in resuming their roles in the workplace and social environment (Jacobsen, Holland & Steensma, 2012; Nitkin, Parkinson, & Schultz, 2011). Little emphasis is being placed on the ways and means to rehabilitate cancer survivors (Pandey & Thomas, 2001). Banning (2011) expressed the importance of the role of the employer in the rehabilitation of the cancer employee on RTW and the need for the employer to be better informed about the needs of the cancer employee. The timely and permanent RTW of cancer patients favourably influences quality of life and economic independence. Work outcomes can be improved by innovation in treatment and support in the managing of symptoms, rehabilitation and the accommodation of disabilities (De Boer *et al.*, 2008, Steiner *et al.*, 2008).

The development of a work-directed intervention could enhance RTW for cancer survivors (Nitkin *et al.*, 2011). An example of such an intervention could be an RTW plan, individual counselling/structural guidance and cognitive behavioural therapy, together with educational pamphlets (Tamminga, De Boer, Verbeek, Taskila & Frings-Dresen, 2010).

Rehabilitation and intervention are, however, not an individual effort but a dynamic multidisciplinary process, which should help the cancer survivor to achieve his or her functional goals (Pandey & Thomas, 2001). It is therefore essential for organisations to be informed about the rehabilitation needs of cancer employees and to be prepared to accommodate these needs. Thereafter a multidisciplinary intervention for cancer patients aimed at RTW must be evaluated for feasibility (Groeneveld, De Boer & Frings-Dresen, 2012).

This study will build on the research mentioned above but the focus will be on the lived experiences of cancer employees when they RTW after treatment.

### **1.3 PROBLEM STATEMENT**

The earlier detection and treatment of cancer lead to an increase in cancer survivors (Grunfeld *et al.*, 2008; Hoffman, 2005; Munir *et al.*, 2009; Pandey & Thomas, 2001; Spelten *et al.*, 2002). Consequently many cancer patients recover and can recommence their daily activities (Kennedy *et al.*, 2006), including RTW. Work after cancer is in fact highly desirable for the cancer survivor from a social and economic perspective (Steiner *et al.*, 2004).

Despite the importance of the reintegration of cancer survivors in terms of their wellbeing and level of performance (to the benefit of the organisation), research points to psychosocial and individual challenges that the cancer survivor has to overcome. Examples are poor communication, information and support, as well as lack of rehabilitation or intervention planning. Research also consistently highlights a need for further exploration into psychosocial and individual issues (Banning, 2011; De Boer *et al.*, 2008, Steiner *et al.*, 2008, Tamminga *et al.*, 2010, Taskila *et al.*, 2011) in order to facilitate cancer survivors' RTW experience better.

It seems that lack of knowledge and understanding about cancer survivors' RTW experiences, on the part of both the employer and employee, contributes to the current challenges identified and addressing this knowledge gap was the aim of this study.

### **1.4 RESEARCH OBJECTIVE AND QUESTIONS**

In light of the preceding problem statement, the overall objective of the study is to explore how cancer survivors experience RTW in order to develop an understanding of how to facilitate and sustain their wellbeing in the work context. The research questions, formulated against the background and rationale for the study, are:

Question 1: What are the challenges that cancer face when RTW?

Question 2: How does the cancer survivor experience these challenges?

Question 3: How do cancer survivors maintain their wellbeing when they RTW?

Question 4: How can these challenges be accommodated and managed to the benefit of both the organisation and the employee?

## **1.5 DISCIPLINARY RELATIONSHIP**

This study is conducted within the discipline of IOP, more specifically in the sub-discipline of employee and organisational wellness. The other sub-disciplines that are applicable in this study of the cancer survivor are personnel psychology, career psychology and ergonomics.

### **1.5.1 Industrial and organisational psychology**

According to Riggio (2009), IOP is the specialist area within the field of psychology that focuses on the study of human behaviour in the work situation. IOP has two objectives, namely to do research to broaden our knowledge of the understanding of work behaviour and secondly to apply that knowledge to improve work behaviour, the work environment and the psychological wellbeing of employees (Riggio, 2009).

Within the field of IOP, the following sub-fields are applicable in this inquiry into the lived experience of the cancer employee's return to the workplace:

- Organisational psychology
- Personnel psychology
- Career psychology
- Employee and organisational wellbeing
- Ergonomics

#### *1.5.1.1 Organisational psychology*

Organisational psychology is concerned with organisations as systems, including individual employees and work groups, as well as the structure and dynamics of organisations (Bergh & Geldenhuys, 2013). Organisational psychology focuses on the influence organisations have on the attitudes and behaviour of their employees and therefore aims to study work at the organisational level in order to understand how workers function in an organisation and how the organisation functions as a whole (Schreuder & Coetzee, 2010). The significance of organisational psychology as a subfield of industrial psychology is seen in the addition of 'organisational' to the name of industrial-organisational psychology, which was known as 'industrial psychology' prior to 1973 (Van Vuuren, 2010). An important

focus is facilitating the [cancer] employee's adjustment, satisfaction and productivity to ensure organisational efficiency, as suggested by Bergh and Geldenhuys (2013).

#### *1.5.1.2 Personnel psychology*

Personnel psychology places greater emphasis on the individual employee. Personnel psychology focuses on measuring and predicting individual differences in behaviour and performance and improving person-work fit (Schreuder & Coetzee, 2010; Van Vuuren, 2010). It is a line function of human resource management in organisations, where it focuses on the attraction, selection, retention, development and utilisation of human resources in order to achieve both individual and organisational goals (Van Vuuren, 2010).

The retention, development and utilisation of the cancer employee on RTW are of major importance to ensure that individual and organisational goals are met.

#### *1.5.1.3 Career psychology*

Career psychology is the subfield of IOP that probably shows the greatest overlap with some of the areas of specialisation of psychology as mother discipline (Van Vuuren, 2010). Some of its areas of focus are the following: the meaning of work in peoples' lives, quality of work life, vocational and career counselling, organisational mental health, stress and work-personal life-balance issues. Where personnel psychology is concerned with the formal employment contract between organisation and employee, career psychology has as core focus the psychological contract (also referred to as the psychosocial contract) between the organisation and the employee (Van Vuuren, 2010).

Career psychology is about optimising the respective expectations of the organisation and the employee and the way in which they are prepared to accommodate each other to ensure the integrity of the psychological contract (Bergh & Theron, 2009; Van Vuuren, 2010). Knowledge of organisational practices related to personnel psychology and organisational psychology (i.e. IOP) assists in understanding specific career issues and challenges faced by certain groups (Coetzee, 2010), such as in this study people with chronic illness such as cancer.

#### 1.5.1.4 *Employee and organisational wellbeing*

This sub-discipline overlaps to some extent with organisational health and safety management and the focus is on keeping employees healthy against physical and psychological onslaughts (Schreuder & Coetzee, 2010). This study will inquire into the effect of cancer employees' physical and psychological situation on their work behaviour and adjustment. The inquiry into the revised role of the individual in the organisation regarding job demands, job design, support structures, work hours and interaction with co-workers could make a valuable contribution to empower these employees.

#### 1.5.1.5 *Ergonomics*

Ergonomics, or engineering and human factors psychology or human-machine systems, is concerned with understanding human performance in the interaction between employees and their technical work environment (Bergh & Geldenhuys, 2013). In a sense, ergonomics is the opposite of personnel psychology. Through ergonomics, the environment is adjusted to be compatible with humans (Schreuder & Coetzee, 2010), whereas the aim of personnel psychology is to fit the human to the job and its requirements (Van Vuuren, 2010).

In the inquiry into the lived experience of the cancer employee's RTW, some employees might need some kind of adjustments to their working environment to make it compatible with their current needs.

### **1.5.2 Meta-theory**

Bates (2005, p.2) has defined *meta-theory* as "the philosophy behind the theory, the fundamental set of ideas about how phenomena of interest in a field should be thought about and researched." Positive psychology is a meta-theory that incorporates various disciplines that have explored human strengths and optimal functioning (Chan, Cardoso & Chronister, 2009). Thus for this study of the cancer survivor's experience on RTW, positive psychology as meta-theory will be discussed.

#### 1.5.2.1 *Positive psychology*

The aim of the positive psychology approach is to change the preoccupation with illness to the improvement of strengths and positive emotions (Coetzee & Cilliers,

2001; Compton, 2005; Seligman & Csikszentmihalyi, 2000). It recognises the importance of learning (growth) and optimistically focusses on a person's future rather than on the past (Henning & Cilliers, 2012).

Positive psychology is “an umbrella term for theories and research about what makes life most worth living” (Park, Peterson & Seligman, 2004). Positive psychology consists of three broad dimensions on specific levels (Bergh & Geldenhuys, 2013), indicated in Table 1.1 below:

**Table 1.1:** The three broad positive psychology dimensions

Subjective level	Study of subjective experiences and positive emotions in the past, present and future
Individual level	Study of positive individual traits
Group or organisational level	The development, creation and maintenance of positive institutions that encourage the development of positive experiences and traits in individuals

One of the distinguishing features of positive psychology, according to Compton (2005), is a focus on the greatest sense of wellbeing, satisfaction or contentment and the good life, which includes relationships with other people and society as a whole. Positive psychology is about human strength, positive emotions, growth in the face of stress and trauma and eventually how to become happier and more fulfilled (thriving) (Lyubomirsky, 2008; Gable & Haidt, 2005).

The field of positive psychology in this study has to do with the scientific understanding of optimal human functioning and the use of effective interventions to develop and enhance thriving individuals and organisations, as suggested by Bergh and Geldenhuys (2013).

### **1.5.3 Meta-theoretical concepts**

Positive psychology includes constructs such as salutogenesis (Antonovsky), fortigenesis (Strümpher), personality hardiness (Kobasa), learned resourcefulness (LR) (Rosenbaum), self-efficacy (Bandura) and locus of control (LOC) (Rotter) – all of which focus on the maintenance or enhancement of wellness in addition to the treatment of illness (Berg & Geldenhuys, 2013; Gropp, Geldenhuys & Visser, 2007). Many constructs have been proposed concerning psychological wellbeing,

including processes involved in the coping of individuals and the enhancement of wellness (Coetzee & Cilliers, 2001). The constructs relevant to the theoretical grounding of this study are sense of coherence (SOC), LOC, self-efficacy, hardiness, potency, LR, optimism, hope, humour, resilience, religion and meaning-making.

For this study, the focus is on the salutogenic perspective, as it describes the extent to which the cancer survivor has a “pervasive and enduring though dynamic feeling of confidence” that the working environment is predictable and that things will work out as expected (Bergh & Geldenhuys, 2013, p 425).

#### *1.5.3.1 Salutogenic perspective*

Being the pioneer of salutogenis (Latin *salus* = health combined with Greek *genesis* = to produce), meaning the origin of health, Antonovsky proposed the study of health instead of disease (Els, 2006). In explaining how people stay healthy, Antonovsky identified generalised resistance resources (GRRs) that help individuals to manage tension in any situation or when faced with any demand (Els, 2006).

Disease and stressors are inevitable and individuals must actively pursue adaptive strategies (Antonovsky, 1996). The salutogenic approach seeks to identify how we can live well with stressors and perhaps even use them to our advantage (Strümpfer, 1990). Salutogenesis looks to the broader realm of the employee with cancer’s wellbeing.

It is being proposed that the paradigm of salutogenesis be broadened to include sources of strength. This approach is named fortigenesis (Latin, *fortis* = strong and Greek, *genesis* = to produce) (Coetzee & Cilliers, 2001; Eriksson & Lindström, 2005). The fortigenic perspective defines the origins of strengths as a more embracing and holistic view to study positive human behaviour. Strümpfer (1995) claims that work experiences are closely linked to fortigenic processes (Hutchinson, 2008). Wissing and Van Eeden (1997) comment on the application of fortology to be used in psychology and name it psychofortology, the science of psychological strengths (Els, 2006).

In summary, the salutogenesis perspective focus on three aspects, namely focus on problem solving, identification of GRRs that help people move towards positive health and identification of “a global and pervasive sense in individuals, groups, populations or systems that serves as the overall mechanism or capacity for this process, the SOC” (Lindström & Eriksson, 2006, p.242). As SOC is the main precept of salutogenesis, it will be discussed in more detail.

### 1.5.3.2 *Sense of coherence*

SOC underpins the salutogenic model (Austin & Cilliers, 2011; Bergh & Geldenhuys, 2013). It is a construct that explains how people’s lives are strengthened through the way in which individuals tend to make sense of the world (Hutchinson, 2008). Wellness can be encouraged by presenting information in an ordered, structured and predictable fashion linking to the comprehensibility aspect of SOC (Coetzee & Cilliers, 2001).

SOC comprises three facets, namely comprehensibility (belief that the challenge is understood), manageability (belief that resources to cope are available) and meaningfulness (to be motivated to cope) (Antonovsky, 1996; Eriksson & Lindström, 2006; Gropp *et al.*, 2007; Jakobsson, 2011). The three components are interrelated and all of them are needed for successful coping. Antonovsky’s hypothesis is that the stronger a person’s SOC, the more likely he/she will be to maintain his/her position on the health ease/disease continuum. Someone with a strong SOC is more likely to:

- comprehend the nature and dimension of a chronic illness (like cancer) (meaning);
- perceive stressors as manageable (mastery);
- be motivated to approach stressors as challenges (self-enhancement).

The formulation of SOC is dependent on the availability of GRRs, which refer to any characteristic of a person (or group), or the environment that can facilitate reducing or eliminating the effects of stress (Antonovsky, 1996). GRRs describe the factors that help people resolve the stresses and difficulties they experience in their lives.

Such resources may be material such as food or money, cognitive attributes such as intelligence or knowledge, interpersonal relationships such as social support, as well as macro-social aspects such as religion (Antonovsky, 1996; Eriksson & Lindström, 2006; Gropp *et al.*, 2007; Jakobsson, 2011; Strümpfer, 1995). A person with a strong SOC will thus be able to mobilise GRRs to combat stressors and a person with a weak SOC is likely to be unable to mobilise adequate resources. People with a stronger SOC are more likely to show readiness and willingness to use resources at their disposal (Eriksson & Lindström, 2006; Strümpfer, 1990).

According to Strümpfer (1990), regarding the workplace, a person with a strong SOC will make cognitive sense of the workplace, perceive work as consisting of experiences that are bearable and will make emotional and motivational sense of work demands. Antonovsky claims that a person with a strong SOC who faces general resistance shortages is likely to seek experiences that balance out stressors and will be able to face difficult life challenges (Strümpfer, 1990; Wissing & Van Eeden, 2002).

High levels of SOC are not only associated with increased levels of job satisfaction, but also present more positive experiences regarding how individuals perceive and perform their work (Strümpfer, 1995). Their implications in promoting occupational health and employee wellbeing therefore become obvious and make SOC applicable in the workplace (Pillay, 2008).

From the salutogenic perspective, the construct SOC will therefore be suitable, as it may contribute to understanding the cancer survivor's RTW process.

#### *1.5.3.3 Other positive psychology constructs used to describe wellbeing*

Many constructs have been proposed to conceptualise aspects of psychological wellbeing, including processes involved in the coping of individuals and the enhancement of wellness. The constructs of importance for this study that may act as coping mechanisms are LOC, self-efficacy, hardiness, potency, LR, optimism, hope, humour, resilience, religion and meaning-making.

*Locus of control* describes the perception of a person about control over his/her behaviour. Rotter describes individuals who believe that they control their lives as having internal LOC and those who attribute what happens to them to outside

influences as having an external LOC (Coetzee & Cilliers, 2001; Gropp *et al.*, 2007; Oosthuizen & Van Lill, 2008).

*Self-efficacy* refers to a person's belief in his/her own abilities to deal with various situations (Coetzee & Cilliers, 2001). Individuals with a high sense of self-efficacy will generally try harder to cope in stressful situations, whereas those with low self-efficacy will focus on negative outcomes and will give up much more easily. Regardless of an individual's ability to behave in a certain way, Bandura believes that action will not be taken unless the individual has the perception of control over his/her situation – this is known as perceived self-efficacy. Individuals will not even attempt to change their behaviour or cope with negative life events if they believe that they have no control over their situation anyway (Bandura, 1997).

*Hardiness*: Kobasa (1979) proposed that people who experience high degrees of stress without falling ill have a personality structure that differentiates them from others who become sick under stress. This personality difference is characterised by the term hardiness. Hardiness consists of three interrelated factors, namely commitment, control and challenge. Individuals who are strong in commitment believe in who they are and what they are doing. Control is a belief that one can influence what is happening to oneself within reasonable limits. Challenge occurs when an individual perceives change as an opportunity for growth rather than a threat. Hardy individuals have an internal sense of personal mastery, confront problems with confidence and take the initiative without manipulating others (Soderstrom, Dolbier, Leiferman & Steinhardt, 2000).

*Potency* refers to a feeling of confidence in personal capacities and confidence in a social order. Ben-Sira (1989) believes that potency is enhanced by good coping outcomes and social support experienced in the past.

*Learned resourcefulness* refers to willingness to learn to be more resourceful to self-manage behaviour (Rosenbaum & Ben-Ari, 1985). LR involves strategies for coping independently with the actions and stress involved in completing daily tasks (Zauszniewski & Bekhet, 2011). Thus resourceful individuals will be better able to deal with challenges. On the other hand, learned helplessness refers to individuals who do not try to get out of a negative situation because the past has taught them they are helpless (Oosthuizen & Van Lill, 2008).

*Optimism:* Scheier and Carver (1985) propose that optimists are individuals who frequently expect to achieve positive outcomes in their lives. Similar to Bandura's ideas about the way self-efficacy influences behaviour, they propose that optimistic individuals will continue with goal-directed behaviour. Optimism is known to be associated with various psychological and physical wellbeing indicators, whereas pessimism has been associated with negative outcomes. According to Hakanen and Lindbohm (2008), optimism may function as a real resource promoting wellbeing and health and according to the results of their study, optimism (and pessimism) may be of particular importance for cancer survivors who RTW. Taylor, Kemeny, Reed, Bower and Gruenewald (2000) also emphasise that optimism may help people cope with stressful and life-threatening events. According to Seligman and Csikszentmihalyi (2000), an optimistic person is more likely to practise health-enhancing habits and make use of social support.

The two constructs of optimism and hope are sometimes used interchangeably. Bruininks and Malle (2005) distinguish between hope and optimism in that hope is an emotion; thus, people will hope for things that are important to them despite the unlikelihood thereof, whereas optimism is more about the probability of an outcome occurring. The construct of hope will, however, be discussed as a separate construct for the purpose of this study.

*Hope:* Hope is another important positive psychology construct related to expectations. Hope is best understood as the perceived capacity to reach goals, along with the ways and means to reach those goals (Snyder, 2004). According to Snyder (2004, p.625), this definition mirrors the definition of hope "expecting the best and working to achieve it". Snyder (2004, p.626) reports that he and his colleagues have found that higher hope repeatedly relates to good outcomes in, among others, health, and that having "too much" hope does not appear to be harmful.

*Humour* is defined as "the tendency of particular cognitive responses to provoke laughter, physical reaction, and provide amusement" ("Humour", n.d., n.a.). According to Bennett and Lengacher (2006), laughter is believed to reduce stress (and the psychological symptoms related to it) and improve self-esteem. Johnson (2002) states that medical research has shown that humour has positive effects

on the immune system and stress levels and may also play a role in the spirituality of people with cancer. Bennett and Lengacher (2006) report that humour is a step to recovery and that it heals and gives hope to survive. According to them, people also use humour to help others to cope, for example cancer survivors joking about hair loss to put others at ease.

*Resilience* is the process of effectively managing significant sources of stress or trauma. Internal individual, life and environmental resources facilitate this capacity for adaptation and “bouncing back” (a return to normal functioning) in the face of adversity (Constanzo, Ryff & Singer, 2009; Windle, 2011, p.152). The experience of resilience will vary across the life course (Windle, 2011).

Resilience addresses two fundamental aspects of adaptation, namely recovery and support. Recovery is important at the acute phase of stressful events or in response to a severe stressor, whereas support is important in coping with ongoing and sometimes constant demands (Hou & Lam, 2013). According to Constanzo *et al.* (2009), they found that having cancer places individuals at risk of increased anxiety and depression. They found that cancer survivors demonstrated resilient functioning in other domains thought to be linked to posttraumatic growth, including social well-being, spirituality and personal growth. Survivors also reported greater spirituality and social actualisation, a belief that society is improving for them and for others.

*Religion:* According to Resnick, Gwyther and Roberto (2011), many people in stressful situations use religion to cope with their hardships. Spiritual/religious resilience is a process in which a person uses spiritual and/or religious beliefs and behaviours as a means of coping (Resnick *et al.*, 2011). Research has demonstrated that religiousness and spirituality are associated with better mental health and quicker adaptation to health problems that lead to better physical health and response to treatment (Gall & Guirguis-Younger, 2013; Hill & Pargament, 2003; Koenig, 2012). According to Yeung and Chan (2007), people with a religion tend to regard God’s help, grace, blessing, mercy and unfailing love as valuable in stressful situations. Religious/spiritual motivation appears to have positive psychological implications, such as greater purpose in life, better life satisfaction,

greater self-confidence, internal LOC, positive affect, better self-image and higher levels of wellbeing (Hill & Pargament, 2003; Yeung & Chan, 2007).

*Meaning-making* is defined as the recovery of meaning or making new meaning when facing highly stressful situations (Park, Edmondson, Fenster & Blank, 2008). Park *et al.* (2008) suggest that cancer survivors' efforts at meaning-making influence the extent to which they successfully derive meaning from their experience, which may, in turn, influence their psychological adjustment. The most common outcomes of meaning-making are having made sense and acceptance (Park, 2010). According to Park *et al.* (2008), searching for meaning has sometimes been shown to be adaptive, but at other times it was related to higher levels of stress and dysfunction. The meaning-making process for cancer survivors involves attempts to fit their understanding of the cancer together with their global meaning to try to reduce the discrepancy between them. According to Park *et al.* (2008), meaning-making is very common in cancer survivors and is believed to be important in their psychological adjustment. Hoffman, Lent and Raque-Bogdan (2013) report that meaning-making is intended to result in improvements such as acceptance, positive reappraisal, integrating the experience into one's identity, or making positive changes in one's life. Rowland (2008) mentions that meaning making for the cancer survivor can result in an increased sense of control and self-esteem, an opportunity to review priorities and an enhanced appreciation of life.

As part of an organisational development strategy, the stimulation and enrichment of employees' coping repertoires will enhance their quality of work life as well as work performance.

## **1.6 ASSUMPTIONS ABOUT SCIENCE AND RESEARCH**

Assumptions refer to basic principles that are assumed to be true without proof or verification (Polit & Hungler, 1993). My ontological and epistemological assumptions that have directed the manner in which I approached this study are discussed below.

### **1.6.1 Ontological assumptions: Relativist position**

Ontology specifies the nature of reality that is to be studied, and what can be known about it (Terre Blanche *et al.*, 2006). In short, it is concerned with what we

believe constitutes social reality (Grix, 2002). Regarding the ontological assumptions of this study, it is assumed that the phenomena of this study, the lived experience of the cancer employee in the workplace, are not only produced through social interaction but that they are in a constant state of revision (Bryman as quoted in Grix, 2002).

I believe that reality is subjective and influenced by the context of the situation, namely the cancer employee's experience and perception, the social environment and the interaction between the individual and the researcher. There are multiple, constructed realities, rather than a single true reality that relates to an ontological position that is known as the relativist position (Ponterotto, 2005).

My ontological assumptions therefore assume the following in the context of this study:

- The work experience of an employee living with cancer is influenced by the cancer and side-effects of the treatment.
- People differ and each one experiences his or her illness in a unique way.

### **1.6.2 Epistemological assumptions**

Epistemology is concerned with the theory of knowledge, in short, about how what is assumed to exist can be known (Grix, 2002). An epistemological position within the interpretivism perspective "is predicated upon the view that a strategy is required that respect[s] the differences between people and the objects of the natural sciences and therefore requires the social scientist to grasp the subjective meaning of social action" (Bryman, as quoted in Grix, 2002, p.178). A constructivist-interpretive epistemology is based on the assumption that the world is constructed, interpreted and experienced by people through their interactions with one another in their "natural setting" (Lincoln & Guba, 1985, p.39; Maxwell, 2013).

I have assumed a constructivist-interpretivist epistemology in the study, as it involves the process of discovering meaning and obtaining knowledge in terms of the understanding of language by means of semi-structured in-depth interviews with participants. The dynamic interaction between researcher and participant is central in the "lived experience" (*Erlebnis*) of the participant (Ponterotto, 2005), as

it were between myself as researcher and the participating cancer employees on RTW.

The assumption is that through intense interaction and dialogue, both the participant and the researcher will reach deeper insight into the lived experience of the cancer employee when returning to work.

## **1.7 ATTENDING TO ETHICAL CONSIDERATIONS**

Terre Blanche *et al.* (2006) mention the four basic ethical principles applicable to research, namely beneficence, non-maleficence, respect for persons and justice.

*Beneficence* is adhered to when the researcher attempts to maximise the benefits that the research offers to the participants, in other words, has the welfare of the participants as goal (Terre Blanche *et al.*, 2006). The benefits of this research were to improve knowledge, which might lead to more effective facilitation of the RTW process for the cancer survivor.

The *principle of non-maleficence* requires the researcher to ensure that no harm befalls research participants. The researcher was therefore prepared at any time during the study to terminate the research if there was reason to suspect that continuation would result in undue distress to study participants. Sometimes, for example, participants were asked questions about their personal views, illness, weaknesses or fears. Such queries might require people to admit to aspects that they found stressful and that they would rather want to forget (Polit & Hungler, 1993). If I sensed that the interview was causing issues to surface that might cause emotional trauma to participants, the interview was ended and/or a follow-up counselling referral was scheduled with the social worker at Oncology, as recommend by Streubert and Carpenter (2011). The participants were informed upfront of this resource. The participants were also given written information on how they could later contact the researcher if they wished to discuss anything.

The *principle of respect for human dignity* includes the right to self-determination and the right to full disclosure (Polit & Hungler, 1993):

- The principle of self-determination (see Mouton, 2001) means that participants have the right to decide voluntarily whether or not to participate in the

study. They also have the right to decide at any point to terminate their participation or to refuse to give information, or to ask for clarification about the purpose of the study or specific questions.

- The principle of respect for human dignity entails people's right to make informed voluntary decisions about their participation in the study. Such decisions cannot be made without full disclosure. This means that I, as researcher, have to describe the nature of the study fully, give the participants the right to refuse participation, explain my responsibilities and the likely risks and benefits of the study. I did this by explaining the nature of the study and by giving participants an information leaflet. I also offered to send participants summaries of the research findings after the data had been analysed.
- Participants gave informed consent, agreeing voluntarily to participate in the research. They were given a free choice to participate or to decline participation.

The *principle of justice* includes the participants' right to fair treatment and the right to privacy (Polit & Hungler, 1993; Terre Blanche *et al.*, 2006):

- Right to fair treatment: The participants had the right to fair treatment before, during and after participation in the study. This was done by fair selection, the honouring of all agreements made between myself and the participants, participants' access to me at any point during the study to clarify information; participants' access to appropriate professional assistance if there was any psychological need and respectful and courteous treatment at all times.
- Right to privacy: Research with humans involves some type of intrusion into their personal lives. I ensured that the research was no more intrusive than it needed to be and that the participants' privacy was maintained throughout the study. Anonymity and confidentiality were guaranteed by putting procedures in place to do so, such as using numbers instead of names and storing information and data in a safe and confidential place.

## **1.8 POTENTIAL CONTRIBUTION OF THE STUDY**

I believe that this study will be useful in at least two major applications. Firstly, it is crucial for management to be informed about the cancer survivor's rehabilitation needs and to be mobilised to facilitate the process of RTW for these survivors. It is important to make employers aware of the complexity of the chronically ill employee and to stimulate critical thinking regarding the current practice in the organisation relating to cancer employees on their RTW. The more information management can gather and process about the cancer survivors' needs, the better informed they will be to facilitate and maintain their well-being.

Secondly, it is hoped that this study will stimulate reflection and critical thinking among cancer survivors regarding the facilitators and barriers in the RTW process and encourage them to make use of the support structures in their respective organisations to facilitate the process.

The study represents original research, which contributes to the current knowledge base of the experiences of cancer survivors when they RTW. I believe that suitable interventions can be planned and executed, after the possible challenges that the employee with cancer encounters in the workplace have been explored and understood. In recognition of individual differences, the potential of cancer survivors can be developed as much as possible to further an optimal work life by also optimising the cancer survivor's adjustment and health in relation to the environment of work.

## **1.9 THESIS STATEMENT**

The cancer survivor experiences unique challenges on RTW because of the cancer and the side effects of treatment and this should be managed by both the employer and employee in order to facilitate productive reintegration into the workplace.

## **1.10 DEFINITIONS OF KEY TERMS**

**Cancer survivor:** According to Clark and Stovall (1996), cancer survivorship is a term used to represent the state of living with the challenges of the cancer experience. A person with cancer is a survivor from the time of diagnosis for the remainder of his/her life. I use the terms cancer survivor and cancer employee

interchangeably to denote living with cancer after having completed treatment and returned to work as well.

**Health:** According to Danna and Griffin (1999), the World Health Organisation defines health as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. Kirsten, Van der Walt and Viljoen (2009), explain health as the state of optimal functioning of a human being, a state of enjoying a good quality of life and experiencing a feeling of complete equilibrium.

**Wellness:** Hurley and Schlaadt (1992) define wellness as an approach to personal health that emphasises individual responsibility for wellbeing through the practice of health-promoting lifestyle behaviours. Wellness is a process that involves striving for balance and integration in one's life (Kirsten *et al.*, 2009), adding and refining skills and rethinking the appropriateness of previous beliefs and stances on issues (Hatfield & Hatfield, 1992).

**Wellbeing:** Dodge, Daly, Huyton and Sanders (2012) define wellbeing as the balance point between an individual's resource pool and the challenges faced. Danna and Griffin (1999), as well as Kirsten *et al.* (2009), suggest that wellbeing is a broader and more encompassing concept that takes the whole person into consideration. According to Kirsten *et al.* (2009), wellbeing refers to the condition of specific aspects of health and wellness, such as the physical, the psychosocial or the social.

According to research done by Kirsten *et al.* (2009), 'health', 'wellbeing' and 'wellness' tend to be used interchangeably. They suggest that the term wellbeing refers to the functioning of the different domains or contexts of a person's life, the promotion of all of which promotes the health/wellness of the person. In the literature review I found that wellbeing and wellness were used interchangeably in the organisational context.

## **1.11 SUMMARY**

Cancer affects people's lives on various levels and individuals living with cancer will perceive their individual experience differently and therefore will respond differently to those experiences (Harrington, 2001).

In this chapter I discussed the background and motivation to the study, gave the identified problem statement, set the research objective and questions, explained the disciplinary context, made assumptions about science and research, discussed ethical considerations, explained the potential contribution of the study, gave the thesis statement, explained the definitions of key terms and provided the chapter layout.

The thesis comprises seven chapters and an outline is given in Table 1.2.

**Table 1.2:** Outline of chapters

<b>Chapter</b>	<b>Chapter title</b>	<b>Content overview</b>
Chapter 1	Research context and rationale	A discussion of the background and motivation of the study, the problem statement, the objective, the research questions, the disciplinary relationship, assumptions about science and research, ethical considerations, the potential contribution of the study, thesis statement, definitions and chapter layout.
Chapter 2	Research methodology	A description of the research design, research method, trustworthiness, ethical considerations and reporting.
Chapter 3	Literature review: Wellbeing of the employee, with specific reference to the cancer employee	Review of books, journals and research reports on the topic.
Chapter 4	Literature review: Strategies aimed at facilitating the wellbeing of cancer survivors in the workplace	Review of books, journals and research reports on the topic.
Chapter 5	Findings	A discussion of the themes that emerged from the data.
Chapter 6	Hermeneutic reflection and integration of data with literature	Further critical hermeneutical reflection and integration of data with the literature follow the initial structural analysis in Chapter 5.
Chapter 7	Conclusions and recommendations	Research questions are answered, together with a discussion of the findings and implications, limitations of the study and suggestions for further research.

Next, in Chapter 2, the research methodology is discussed.

# **CHAPTER 2**

## **RESEARCH METHODOLOGY**

### **2.1 INTRODUCTION**

When selecting a research design, the research question(s) needs to be taken into account, as it will help to focus the study and to give guidance on how to conduct it (Maxwell, 2009; Terre Blanche *et al.*, 2006). A qualitative approach is used because the essence of the study is to listen to and to understand the lived experience of cancer survivors when they RTW. This is a hermeneutic phenomenological study, incorporating semi-structured in-depth interviews and thematic analysis. This study is conducted in the South African Little Karoo and South Cape area, on cancer survivors who have completed cancer treatment and have returned to work.

The previous chapter gave the background and introduction to the research. In this chapter I focus on providing an overview of the research process, a description of the research design, population, sampling, data collection and analysis, trustworthiness, ethical considerations and reporting.

### **2.2 OVERVIEW OF THE RESEARCH PROCESS**

The research methodology refers to the steps in the research process and is inclusive of the population and sample, data collection, rigour and data analysis (Klopper, 2008). The research process used in this study will therefore be explained according to Table 2.1.

**Table 2.1:** Research process of this study

<b>CONTINUOUS LITERATURE REVIEW</b>				
Research questions	Selection of site and participants	Collection of data	Data analysis	Writing up of findings/ conclusions
1. What are the possible challenges that employees with cancer face in the working environment? 2. How does the cancer employee perceive these challenges? 3. How can these challenges be accommodated and managed to the benefit of both the organisation and the employee? 4. How do cancer employees maintain their wellbeing when they RTW?	Participants who fit the criteria (completed cancer treatment and are employed) are selected at oncology institutions or cancer support groups in the Little Karoo and Southern Cape. Purposive, voluntary and the snowballing methods of sampling are used in this study (Terre Blanche <i>et al.</i> , 2006).	Semi-structured in-depth interviews are held with participants. One main question is asked and the narratives are only interrupted to probe for further information when needed. The nature and emotion involved in the telling of their experiences, lead the researcher to let the narrative flow and not to interrupt unnecessarily.	The research text is analysed using the data analysis method, as suggested by Van Manen (1984) and Tesch (1990). The researcher also uses an external person for data analysis for verification.	In the findings that follow the data analysis, a qualitative reporting style is used in which the major and sub-themes that emerged are integrated and discussed. The participants' verbatim responses are also given to illustrate the results. A further hermeneutical reflection follows, whereafter the conclusions and recommendations are presented.

### 2.3 PURPOSE OF THE RESEARCH

My own experience as a cancer survivor and the contact that I have with other cancer survivors directed me to design a study exploring the lived experience of the cancer survivor in the work place. I therefore interacted with the participants in collecting and interpreting the data to gain insight into their unique experiences.

### 2.4 RESEARCH DESIGN

The research design is a practical plan for the methods to be used. Following a well-planned research design ensures reaching a credible conclusion(s) based on the evidence generated by the research (Harding, 2013, p.15). According to Terre Blanche *et al.* (2006, p. 34), a research design is a “strategic framework for action that serves as a bridge between [the] research question and the execution or implementation of the research”.

An explication of the research design follows, clarifying the paradigm, the type of study and the orientation of the study.

### **2.4.1 Theoretical paradigm informing the research**

“Paradigms are systems of interrelated ontological, epistemological, and methodological assumptions. Paradigms act as perspectives that provide a rationale for the research and commit the researcher to particular methods of data collection, observation, and interpretation” (Terre Blanche *et al.*, 2006, p. 40). A paradigm represents a belief system that links the researcher to a particular worldview (Denzin & Lincoln, 2011).

According to Polit and Hungler (1993), qualitative research is often described as holistic and naturalistic. It is based on the assumption that knowledge about humans is not possible without describing human experience as it is lived and as it is defined by the individuals themselves (Terre Blanche *et al.*, 2006). For this qualitative study, the interpretive (constructivist) paradigm was appropriate. I wanted to explore the world of cancer survivors, their questions, challenges, hope and fears, in the working environment and to interpret its meaning emphatically.

“Constructivism adheres to a relativist position that assumes multiple, apprehendable and equally valid realities” (Ponterotto, 2005, p.29). People construct their own realities and a hermeneutical approach is used, which maintains that meaning is hidden and must be brought to the surface through deep reflection and interpretation. This reflection can be done through researcher-participant dialogue (Ponterotto, 2005). Therefore, it is important for me to interact with cancer survivors and to focus on the specific contexts in which they live and work in order to understand their lived experience when they return to work.

### **2.4.2 Type of study: Qualitative research**

#### *2.4.2.1 Features of qualitative research*

Qualitative research is about the search for people’s truths. In understanding their truths and their realities, one can try to begin to understand their actions. In a qualitative world, no single, universal truth exists. Each person has an understanding of reality (truth) from an individual perspective (Morrison, Haley, Sheehan & Taylor, 2012). There is fairly wide consensus that qualitative research is a

naturalistic, interpretative approach concerned with understanding the meanings that people attach to phenomena within their social worlds (Harding, 2013; Hoepfl, 1997; Miles & Huberman, 1994; Ritchie & Lewis, 2003). The interpretive approach is concerned with understanding as it is from the subjective experiences from individuals. Thus methods such as interviews or observation that rely on the subjective relationship between the researcher and participants are used. The interpretive approach aims to explain the subjective reasons and meaning that lie behind social action (Terre Blanche *et al.*, 2006).

The feature of qualitative research is that it aims at providing an in-depth and interpreted understanding of the social world of research participants by learning about their experiences and perspectives (Polit & Hungler, 1993; Polkinghorne, 2005). The sample is usually small in scale and purposively selected on the basis of specific criteria. The data collection methods entail close contact between the researcher and the research participants (Ritchie & Lewis, 2003). The process requires a maximum of the researchers' involvement, as the researcher tries to comprehend the participants' experiences (Polit & Hungler, 1993). Data are very detailed and comprehensive and analysis produces detailed descriptions and explanations (Hoepfl, 1997; Miles & Huberman, 1994; Ritchie & Lewis, 2003).

#### *2.4.2.2 Assumptions of qualitative research*

The qualitative research paradigm assumptions used in this research are similar to those proposed by Joubert (2012):

- People differ and each one makes sense of his/her life and experiences in a unique way.
- The researcher interacts closely with the participants to explore their lived experiences and perceptions.
- The researcher is the primary instrument for data collection and analysis, therefore the research is influenced by the values of the researcher.
- The research involves fieldwork. The researcher selects suitable participants and continues to collect data until data saturation occurs.
- The process is inductive and conclusions are drawn from the information gathered from participants.

#### *2.4.2.3 Strengths and weaknesses of qualitative research*

However suitable for a specific study, qualitative research is not without its weaknesses and limitations. Some of the key strengths and weaknesses of qualitative research will next be pointed out.

The strengths of qualitative research are that it is useful for studying a limited number of cases in depth and it provides understanding and description of people's personal experiences (Johnson & Christensen, 2012; Maxwell, 2013). According to Miles and Huberman (1994), the strength of qualitative data is that they provide thick descriptions in a real-life context.

The weaknesses of qualitative research are that findings might not be generalised to other people or settings, it is more time-consuming and the results are more easily influenced by the researcher's personal biases and views (Johnson & Christensen, 2012).

#### *2.4.2.4 Rationale for using qualitative research*

Creswell (2003) proposes that in selecting a research approach, the following must be considered: the knowledge claim, the chosen strategy and what methods are going to be used.

In this study a constructivist knowledge claim is made. According to Creswell (2003) and Crotty (2003), assumptions in social constructivism are about individuals that seek understanding of the world in which they live and work. In seeking understanding, the individuals develop subjective, multiple and different meanings of their experiences. These diverse meanings of the various individuals lead the researcher to look for complexity of views rather than narrowing these meanings into a few categories (Creswell, 2003). The goal of research, then, is to rely as much as possible on the participants' views of the situation being studied. The questions are broad and general so that the participants can construct the meaning of the situation. The researcher recognises that her own background shapes her interpretation, and she uses this to position herself in the research (Creswell, 2003). The strategy of inquiry will be hermeneutically phenomenological, as will be discussed in section 2.4.3.1 below. Since I believe that the reality to be studied consists of the cancer survivor's subjective experiences, I will

use interviewing as a method to collect data (as suggested by Terre Blanche *et al.*, 2006).

Also important when choosing a particular research method is to consider the research question(s), the researcher's personal experience and the audience to whom the findings will be made available (Cresswell, 2003). To answer the four research questions, it is necessary to get a rich description of the lived experiences of the cancer survivors. My personal training, experience and preference incline towards interacting with participants and conducting interviews. The audience to whom these findings will be of interest would be cancer survivors, people working in the human resources field, health workers, as well as employers, managers and industrial and organisational psychologists who deal with the well-being of the organisation and the employee.

Considering all these issues, I chose qualitative research as the most suitable approach to gain information and/or new perspectives on cancer survivors' lived experience when they RTW.

### **2.4.3 Research approach/orientation**

I found that when listening to my sister talking about her RTW experience after her cancer treatment (the phenomenon), I reflected and compared it with my own experience and wanted a deeper understanding of the meaning of this experience. I decided to use this approach of storytelling and by interpreting and reporting in a (hermeneutic) way to represent what is intended by the participants. This method of hermeneutic phenomenology will thus be described.

#### *2.4.3.1 Hermeneutic phenomenology*

Hermeneutic phenomenology, being the process of interpreting and describing human experience as it is lived (Laverty, 2003; Tan, Grief & Couns, 2009), is a well suited methodology for this study because the researcher wanted to describe and understand the lived experience of cancer survivors when they RTW.

Van Manen (1984) defines the methodological process as an interaction among four activities: Firstly the researcher chooses a human phenomenon of interest, secondly the phenomenon is examined as it is lived, thirdly the themes that describe the phenomenon are identified and lastly the researcher engages in the

act of understanding. In this process the researcher understands that “everything is interrelated: the whole is more than the sum of its parts and the whole makes the parts what they are” (Guimond-Plourde, 2009, p.4).

The biases and assumptions of the researcher are part of and essential to the interpretive process and the researcher’s personal reflections are included in the research (Van Manen, 1984; Lavery, 2003). Within the phenomenology the intent is to clarify the conditions that can lead to understanding. Hermeneutics has to do with understanding or *Verstehen*. I must be willing to merge what I know with what others know about the phenomena. To accomplish understanding there must be a back-and-forth movement of language to disclose the experiences that we live and only then can common meaning be shared and learning through experience begin (Holroyd, 2007; Van Manen, 1984).

In this co-creation of meaning I therefore interacted with the cancer survivors in sharing, using self-reflexivity and interpreting this complex lived experience called cancer survivorship.

## **2.5 RESEARCH METHOD**

Klopper (2008) indicates that the research methodology includes the steps of population and sample, data collection, ensuring rigour and data analysis. The research method is a technique that is used to organise and structure a study in a systemic manner from the start to the end. In the following section I therefore discuss the sampling method, data collection, recording and transcription of data and data analysis.

### **2.5.1 Sampling**

Sampling is the selection of research participants from a population and involves decisions about (who) people, (where) settings, events, (what) behaviours and/or social processes that will be observed. The aim is to select a sample that will be representative of the population about which I aim to draw conclusions and that will provide a substantial contribution to the study (Polkinghorne, 2005; Terre Blanche *et al.*, 2006).

### 2.5.1.1 *Research setting/population*

A population is the entire collection of cases that meets a specific set of criteria (Polit & Hungler, 1993; Terre Blanche *et al.*, 2006). The population of this study is all the cancer survivors who have completed their cancer treatment and have returned to work within the Southern Cape and Little Karoo area. People who have completed their cancer treatment and have returned to work were targeted. I chose people who had completed their treatment, because the treatment takes time and there might have been other issues, such as sick leave that the employees had to take, that could have had an influence on the results of the study. The individual (cancer survivor) was the unit of analysis and had an impact on sample selection, data collection and the type of conclusion(s) that was drawn from the research (Terre Blanche *et al.*, 2006). Polkinghorne (2005) is of the opinion that the unit of analysis in qualitative research is experience, not individuals or groups. The participants were sourced at an oncology institution by visiting the division for a period of time and at a cancer support institution where cancer survivors received assistance and help with specific needs.

### 2.5.1.2 *Entrée and establishing researcher's role*

In interpretive research it is the researcher who is the primary instrument for both collecting and analysing the data. In interpretive research, subjectivity is part of the process that makes it possible to understand personal and social realities with empathy. According to Peshkin (1988), subjectivity can be seen as beneficial to the process, for it is the basis of adding the researcher's personal experiences to the experiences of those who are studied.

Oncology and support institutions were targeted to conduct the research, as I believed that suitable participants might be recruited there. Even when people with cancer have completed treatment, they still need regular follow-up care and these follow-up appointments are usually scheduled with the oncologist who assisted the person during treatment. The support institutions for people living with cancer render different services for cancer survivors and they have a database of these survivors.

The contact person at the oncology institution was the practice manager. A working relationship was established with her by explaining the research and by

getting written permission to advertise and to conduct interviews with voluntary participants. The contact person at the targeted cancer institution was the medical sister who had contact with cancer survivors. I am a volunteer at this institution and have a good relationship and understanding of the protocol of the institution. Contact details were obtained by the sister, who contacted cancer survivors whom she thought would be willing to volunteer to participate in the inquiry. They were only contacted when they consented to potential participation in the study.

Posters with information about the research were put up at the oncology division and I visited the division for a period of time. The participants were requested to sign a consent form and the researcher explained the context and the purpose of the study to the participants. Voluntary participation was requested and confidentiality of participation and information were ensured. Individual interviews and discussions were scheduled at a convenient place and time for all involved. Pre-questions were asked to ensure that the participant met the criteria before participating in the study. During the interview it was established that the interviewee was comfortable with the level of exploration, discussion and recording of the interview.

#### *2.5.1.3 Sampling method*

According to Flick (2009), in sampling the researcher will construct the cases he or she will study. Probability sampling occurs when each element in a sample frame should have a known, calculated chance of being included in the sample. Non-probability sampling is a sampling technique where the samples are gathered in a process that does not give all the individuals in the population equal chances of being selected (Terre Blanche *et al.*, 2006).

Non-probability, purposive, voluntary and snowballing sampling were used in this study. Participants were from the Southern Cape and Little Karoo area, because of the researcher's resource constraints (funding, distance, etc.). In order to select the most productive sample to answer the research questions, the selection of participants was purposeful and participants were sought out (Marshall, 1996), as they had to adhere to the predetermined sampling criteria of being a cancer survivor and having returned to work. Patton (2002) argues that it is important to

select cases that are information-rich (those from which one can learn a lot about issues of importance to the purpose of the research).

Purposive sample means that sampling depends not only on availability and willingness to participate, but that the cases are diverse enough (and meet the criteria) to enhance rich and unique stories of their particular experience (Laverty, 2003; Patton, 2002). During the recruiting of participants, I asked cancer survivors to direct me to other possible participants who met the criteria. This process of gradually accumulating a sufficient sample through references is called snowballing sampling (Terre Blanche, *et al.*, 2006). One participant was recruited through the snowballing method, five were recruited with the help of the cancer institution, one was recruited at the oncology division and one was recruited by me. In total eight participants were included in the study.

Convenient sampling was not suitable for this study's purpose because it is a type of sampling where the first available primary data source will be used for the research without additional requirements. In other words, this sampling method involves getting participants wherever one can find them and typically wherever is convenient. In convenience sampling no inclusion criteria are identified prior to selection of subjects. All subjects are invited to participate (Polit & Hungler, 1993). In this study there were inclusion criteria, thus purposive sampling was more appropriate.

#### *2.5.1.4 Sampling criteria*

Participation was voluntary and participants were encouraged to talk about their experiences. The primary sampling parameters were that participants who were diagnosed with cancer:

- had to have completed initial cancer treatment; had to have returned to work and
- had to be living in the South Cape or Little Karoo area.

One of the participants met the criteria mentioned above, but she was awaiting more treatment. She had the initial cancer treatment, had returned to work and lived in the South Cape area. The cancer returned and she had to undergo more treatment. At the time of the interview, she had returned to work and was awaiting

more treatment. She was included in the study, as I felt that she met the initial criteria and could make a valuable contribution in sharing her experience.

### 2.5.1.5 The sample

Ten people were identified, but only eight (8) were prepared to participate in the study. Table 2.2 depicts the biographical data of the participants in this study:

**Table 2.2:** Biographical data of participants

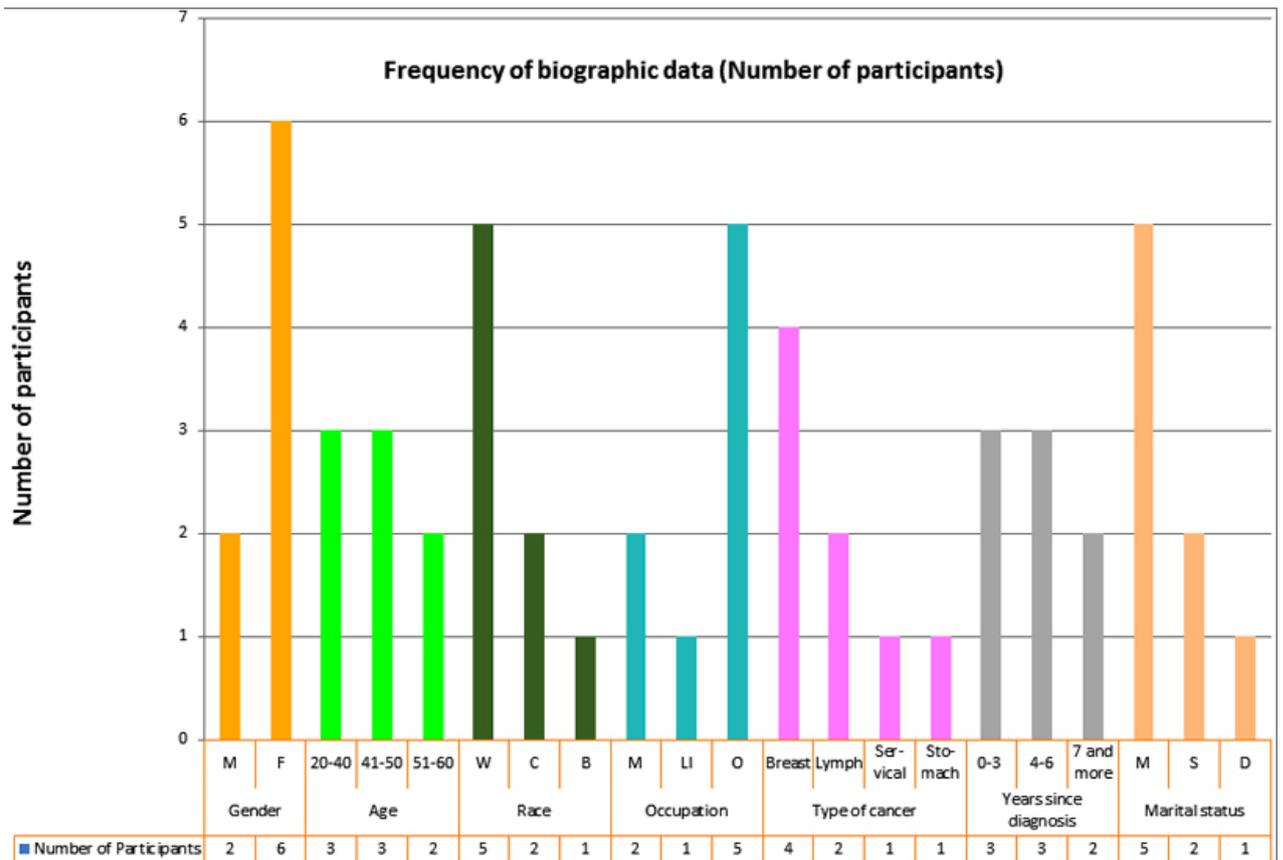
Gender	Age	Race	Occupation	Type of cancer	Period since cancer diagnosis	Home language	Marital status
Male	28	C	Forensic pathology officer	Lymph node	4 years	Afrikaans	S
Female	59	C	Teacher	Breast	5 years	Afrikaans	M
Female	57	W	Cashier	Breast	7 years	Afrikaans	M
Female	39	W	Sales assistant	Breast	2 years	Afrikaans	D
Female	45	W	Community mobiliser	Breast	8 years	Afrikaans	M
Female	40	W	Personal assistant	Cervical	6 years	Afrikaans	M
Male	44	W	Deputy director administration support	Hodgkin's lymphoma	2½ years	Afrikaans	M
Female	47	B	Operational manager (hospital)	Stomach (metastatic cancer)	3 years	Xhosa	S

C = Coloured, B = Black, W = White

S = Single, D = Divorced, M = Married

Seven participants were in remission. The definition of remission by the National Cancer Institute (n.d.), is a decrease in or disappearance of signs and symptoms of cancer. In partial remission, some, but not all, signs and symptoms of cancer have disappeared. In complete remission, all signs and symptoms of cancer have disappeared, although cancer may still be in the body. One participant had metastatic stomach cancer, which means that the cancer had spread to another location in the body. The goal of treatment at this stage is typically to lengthen a patient's life and care for the symptoms of the cancer, since metastatic stomach cancer is not considered curable (Stomach cancer, 2013).

Figure 2.1 provides an overview (frequency) of the biographical data of the participants:



Gender: M = Male, F = Female

Race: W = White, C = Coloured, B = Black

Occupation: M = Management, L = Labour intensive, O = Office

Marital Status: M = Married, S = Single, D = Divorced

**Figure 2.1:** Frequency of biographical data of the participants

### 2.5.1.6 Introducing the participants

The participants are introduced by giving a short biographic description and a brief background of each interview. The participants are numbered from 1 to 8 and the abbreviations P1 – P8 are used.

**P1:** A single working young man in his late twenties with a positive outlook on life in general. He was diagnosed in 2008 with lymph node cancer. He underwent intensive chemotherapy, which made him very ill. The type of work that he does requires physical labour and he mentioned that he does not always have the strength to do certain tasks. The interview was held in an office at the oncology division where he had an appointment with the oncologist for a routine check-up. He was a bit stressed, but he talked freely about his experience and used the phrase “it is what you make of it yourself” a lot.

**P2:** A working married women in her sixties. She was diagnosed with breast cancer five years previously. She had a mastectomy, chemotherapy and radiation. She was very open and forthcoming in sharing her experience. She is a teacher and the interview was held in the library at the school. She is a person whom is respected by her colleagues as well as the children. She considers going on early pension. A support system is very important to her and she mentioned that her husband and family do not understand that she is not the same as before because she does not look ill. They expect her to continue as before the cancer diagnosis.

**P3:** A working married women in her late fifties. She was diagnosed with breast cancer in 2006 and had a lumpectomy, radiation and chemotherapy. She has a strong family history of cancer and she became very emotional during the interview in reliving the cancer experience. She works with her husband in their butchery and this makes it easier for her to take time off when needed. She used a lot of humour during the interview and shared information freely. The interview was held at her home. She cares for her elderly father who lives in a home and she treasures her relationship with him.

**P4:** A divorced working woman in her late thirties. She was diagnosed with breast cancer in 2012. She had a mastectomy and chemotherapy. She works as a saleslady at her ex-husband's garage. She runs marathons and is very fit. She admitted that she was depressive and became emotional during the interview. The interview was held in a coffee shop, which was not a preferable venue but was the only option at that stage. She cared for her child and showed concern about how the child experienced her cancer diagnosis.

**P5:** A married working woman in her middle forties. She was diagnosed with breast cancer in 2005 and had a mastectomy, chemotherapy, radiation and hormone treatment. She offered counselling and support for cancer patients. The interview was held at her workplace. She knew a lot about the subject of cancer. She was very reserved and many probing questions had to be asked to get her to share. She mentioned that she had a 'cancer body' and would one day die because of cancer.

**P6:** A married working woman in her early forties with cervical cancer. She was diagnosed in 2007 and only had surgery. She worked as an assistant to a financial consultant. She also wrote and published poetry. She talked freely about her experience. She had a difficult childhood because of various illnesses. The interview was held at her workplace. She also mentioned her concern for the 'care-givers', the husbands and children who have to care for the cancer patient.

**P7:** A married working male in his mid-forties. He was diagnosed with Hodgkin's lymphoma in 2011. He only had chemotherapy. He was in a managerial position and this made the RTW a little easier because he could delegate some work. He was very emotional in telling his lived experience and talked in the third person to distance him from the experience. He uttered "ahm" often in the interview, as if to collect himself and his thoughts. The interview was held at his workplace. He shared his re-evaluation of his life and priorities and mentioned that he tried to bring about some changes in his life.

**P8:** A single woman in her late forties. She was diagnosed with metastatic stomach cancer in 2011. She mentioned that when she heard she had cancer she cried a lot and thought about suicide. She had surgery, chemotherapy and radiation. She became very sick because of the chemotherapy and radiation and said that for her it was worse than the surgery. The cancer returned (spread) and she had to go for more chemotherapy. She was very reserved and told her story clinically, as if she detached herself from the reality. She was in the health profession and had good knowledge of cancer. The interview was held in the town library. She is also busy with extra-mural studies. She had a daughter in her twenties and lived with family members. She was glad to RTW, to be able to socialise and be busy. In an effort to lighten the mood, she told some funny stories of things that had happened at work and laughed at herself.

## **2.5.2 Data collection**

The purpose of data gathering in qualitative research is to provide evidence for the experience it is investigating. The data serve as the ground on which the findings are based. The data that accumulates from studying lived experiences need to be gathered from an intensive exploration with a participant. Such an exploration results in languaged data (Polkinghorne, 2005).

Semi-structured in-depth interviews were held with participants. One open-ended question was asked. The researcher explored by asking participants to elaborate on thoughts and feelings to get a rich description of their experiences (Terre Blanche *et al.*, 2006, p 299). The broad question was followed by predetermined probing questions (Banning & Griffiths, 2014).

Before the interviews took place, participants were informed about the study details and they were assured about ethical principles, such as anonymity and confidentiality. The interviews were (where possible) conducted in areas free from distractions and at times and locations that were most suitable for participants. Sharing an experience with participants enhances the researcher's ability to enter the research setting and establish rapport with participants (Gill, Stewart, Treasure & Chadwick, 2008). The fact that the researcher is also a cancer survivor therefore helped in establishing a sharing and open relationship with the participants prior to the interview. The interviews were limited to one hour, as the researcher found that adequate information was gathered in that time and after that the participants got tired and no new information came to the fore.

One of the most important skills I had to apply was to listen attentively to what was said so that the participants were able to tell their stories without unnecessary interruptions. Other skills I had to apply included demonstrating open and emotionally neutral body language, nodding, smiling, looking interested and making encouraging noises (e.g. "Mmmm") during the interview (Okun & Kantrowitz, 2008). This was not always possible, as some of the participants got very emotional when recollecting their experiences and I had to acknowledge their emotions by showing sympathy. To develop the interview further, I included reflecting remarks made by participants (e.g. "pain?") and explored remarks (e.g. "how...?") (Gill *et al.*, 2008). At the end of the interview they were thanked for their time and asked if they would like to add anything. They were also asked if they would like to get feedback on the research and arrangements were made for this.

I wanted to interview approximately 10 participants or enough to reach data saturation. The question about the number of cases in qualitative research is whether the sample will provide sufficient data to answer the research question and objectives thoroughly (Liamputtong, 2009). Data saturation was reached after

eight interviews as the “account was richly fed by the material that has been collected” (Terre Blanche *et al.*, 2006, p. 372) and no new themes emerged.

### **2.5.3 Recording of data**

I made use of digital recordings and a verbatim transcription of the interviews was made. I clarified uncertainties or ambiguities and ensured that the interpretation of the data was not based on my own experience, but from the reference area of the participant (reflecting) (Terre Blanche *et al.*, 2006).

During the interview, I observed and kept a reflective diary where any noteworthy observation was noted. I also made field notes regarding the interview setting, the non-verbal language of the interviewee and my own personal feelings and impressions. Things that happened that might not be obvious from listening to the recording were noted, as recommended by Terre Blanche *et al.* (2006). These observation notes therefore provided a written account of what I saw, heard, experienced and thought during the interview and could contribute to more depth and detail in the research findings.

I also used communication techniques such as minimal verbal response, paraphrasing, reflection, clarifying and summarising to encourage participants' elaboration on feelings, thoughts, experiences and perspectives (see Neuman, 2003). In addition to the verbal information obtained during the interviews, I took observation notes (also referred to as field notes) immediately after each interview. Personal notes served, as suggested by Bester and du Plessis (2010), to reflect on my own experiences, for example my emotional and physiological state, as well as my experience of the participants. These observation notes therefore provided a written account of what I saw, heard, experienced and thought during the interview and could consequently contribute more depth and detail to the research findings.

### **2.5.4 Transcription of data**

The audio recordings of the individual interviews were transcribed verbatim.

“In a qualitative study, there is no clear point at which data collection stops and analysis begins” (Terre Blanche *et al.*, 2006, p.321). Groenewald (2004), quoted Hycner (1999) who mentioned that the term analysis usually means “breaking

into parts” and therefore often means a loss of the whole phenomenon, whereas explicitation implies an investigation of the smaller parts of a phenomenon while keeping the context of the whole. The terms analysis and explicitation will be used, but I prefer the use of the term explicitation, as it describes the unfolding of the cancer survivor’s experiences.

The process of explicitation started while interviewing the participants. I already got a “feel” for the data during the interview process and reflecting notes were made to help with the process.

The individual interviews were typed as follows:

<b><i>INDIVIDUAL INTERVIEW WITH PARTICIPANT ONE</i></b>	
<b>A21</b>	<u>Researcher’s question</u> : Please tell me about your experience when you returned to work after treatment.
<b>A22</b>	<u>Participant one’s answer</u> : Look what I can say now, it is easier if I go to patients.
<b>A25</b>	I have more understanding since I was in the same position.
<b>A30</b>	<u>Researcher’s question</u> : How do the cancer and after-effects affect your work?
<b>A31</b>	<u>Participant one’s answer</u> : Now and then it is a little detrimental, patients are sometimes heavy to carry – in situation, lot of walking in
<b>A32</b>	search and rescue. After some time you start to adjust. Currently I still get tired. Sweat a lot and get
<b>A33</b>	tired. Long-term chemo not just yet out of system. Chemo takes five to eight years or more, depending on
<b>A34</b>	how your body handles it, to disappear from the system. At the present moment I handle it okay.

### **INDIVIDUAL INTERVIEW WITH PARTICIPANT TWO**

- B114** Researcher's question: Please tell me about your experience when you returned to work after treatment.
- B115** Participant two's answer: Physically or emotionally?
- B115** Researcher probes: Both?
- B116** Participant two's answer: It is quite ... Before I could do anything.
- B117** Previously I could manage everything, but no longer. I am not as quick as before because of my
- B118** mastectomy. My arm does not allow me to do everything. Previously, when the children performed well ... I
- B119** cannot pick them up as before, when they did well. But now it is no longer so easy. Writing on the
- B120** blackboard is hard, but I made a bench for myself to stand on. To make it easier ... I made it easier for
- B121** myself.
- B136** Researcher's question: How does your employer handle these challenges?
- B137** Participant two's answer: You know what, I'd rather not talk about my employer. But my husband! Do not know whether he is in
- B138** denial, but for him it was always so ... I can still do stuff – he wants me to continue as before. I do
- B139** not like working at home at all. My children, they want something ... and then I make it. They act as if there
- B140** is nothing wrong.

### **INDIVIDUAL INTERVIEW WITH PARTICIPANT THREE**

- C242** Researcher's question: Please tell me about your experience when you returned to work after treatment.
- C243** Participant three's answer: I decreased my hours. I still went to work, trying to work full hours, but then after two to three hours, I felt so tired
- C244** that if I did not get to a bed ... I felt as if I would kill for a bed. Terrible thing. An hour or so sleep ... then I proceed.
- C245** Researcher probes: And your arm?
- C246** Participant three's answer: My arm started about three years after I burned it, I got lymphedema. Cannot pick heavy things up. Sometimes you have to pick stuff up, there is not always someone to help ...

### **INDIVIDUAL INTERVIEW WITH PARTICIPANT FOUR**

- D290** Researcher's question: Please tell me about your experience when you returned to work after treatment. Are there anything more difficult at work now after your cancer diagnosis?
- D291** Participant four's answer: No ... except I am very forgetful and must keep a diary.
- D292** Participant four continues: I am very tired. I go to sleep early. I am in bed at 8.
- D293** (Researcher just nods and listens attentively.) Participant four continues: Concentration is difficult.
- D293** Researcher probes: In what way?
- D294** Participant four answers: I must put in more effort to concentrate. I put something down here, then take another thing. I am not quite focussed.

### **INDIVIDUAL INTERVIEW WITH PARTICIPANT FIVE**

- E366** Researcher's question: Please tell me about your experience when you returned to work after treatment.
- E367** Participant five asks: Do you mean emotionally?
- E367** Researcher probes: Yes or physically or any other way?
- E368** Participant five answers: I was always tired, it's something that does not go away. I work all day. I work rough hours. Work
- E369** even Saturday evenings as well. At first I worked half days. Had to lie down every afternoon.
- E398** Researcher probes: Anything else?
- E399** Participant five answers: The hearing in my one ear is affected due to chemo and then I also find it hard to remember.
- E400** Researcher probes: How does it affect your work?
- E401** Participant five answers: Both are very bad for me. I went to test a hearing apparatus. Once there is background noise, I cannot
- E402** hear. My hearing is bad. I got the device for testing, but it's so expensive ... So it is still difficult.

### **INDIVIDUAL INTERVIEW WITH PARTICIPANT SIX**

- F526** Researcher's question: Please tell me about your experience when you returned to work after treatment.
- F527** Participant six's answer: I think you ... go through your own battle, if I may say so. The type of work that I do is with people affected by
- F528** trauma or disability or even by death. For that matter I would have more sympathy and passion.
- F559** Researcher's question: What advice do you have for employers and cancer employees?
- F560** Participant six's answer: Six months may be long in time, but six months, ah I mean six weeks, for the ill person is not always enough.
- F561** If a person needs more time, to have sympathy with that person whether it is unpaid leave or whatever – it will
- F562** help. Keep an open door, as needed for that person. If he cannot return after those six weeks, that it will be
- F563** discussed beforehand.

### **INDIVIDUAL INTERVIEW WITH PARTICIPANT SEVEN**

- G586** Researcher's question: Please tell me about your experience when you returned to work after treatment.
- G587** Participant seven's answer: See the original return, I need to work it out ... May in hospital ... Finished treatment in the following
- G588** year February ... where are we now ...
- G589** So that's two years after my initial treatment started. After my treatment started, I was booked off ...
- G591** Participant seven continues: The work itself is not really an issue ... I could catch up quickly.  
(Researcher just nods encouragingly and listens attentively)
- G592** Participant seven continues: The things that get to you in the beginning ... a lot of pain ... scars will be there. You wonder what is this
- G593** pain ... and short-term memory is a goner. And the hot flushes...

### ***INDIVIDUAL INTERVIEW WITH PARTICIPANT EIGHT***

- H803** Researcher's question: Please tell me about your experience when you returned to work after treatment.
- H804** Participant eight's answer: It was very nice for me. Because during the treatment I had to stay in my place, because if I went out, the
- H805** moment I went out my immune system went down. I wasn't allowed to go to the shops, I wasn't allowed to go
- H806** to my workplace. I wasn't allowed to ... also when I received visitors, I had to restrict them.
- H815** Researcher probes: And your work itself, could you still manage everything?
- H816** Participant eight's answer: I still managed my work. You see, when I came back, people they were ... they said, you are not supposed
- H817** to wash patients, you are not supposed to do that. I said I am going to do that. If I am going to sit there
- H818** watching you moving around, it brings back the memories where I was sitting at home looking at people
- H819** walking around. So I want to feel I am part of the team.
- H834** Researcher's question: Are there some things at work that are difficult to handle?
- H835** Participant eight's answer: (shakes head) Ah ah. It is just the same. Difficult staff members as they used to be difficult. Taking advantage as they used
- H836** to take advantage (laughs).

Each typed line was numbered. For example, for participant one the numbering of lines started at A1, for participant two the numbering of lines started with B97, for participant three the numbering started at C185, for participant four it started at D279, participant five started at E348, participant six started at F450, participant seven started at G580 and participant eight started at H733. This technique made data analysis much easier because when I had to return to the typed interviews, the specific statement could easily be found (Tesch, 1990).

#### 2.5.4.1 Translation problems

Since the study was done in the Southern Cape and Klein Karoo region, most of the participants were Afrikaans-speaking. One participant was Xhosa-speaking but she was fluent in English and the interview was conducted in English. Afrikaans is the home language of most of the people living in the Southern Cape and Little Karoo areas. My home language is also Afrikaans, so no language difference was experienced in data gathering, transcription and during the first analyses. According to Van Nes, Abma, Jonsson and Deeg (2010), usually the first coding phase stays closely to the data.

I first transcribed the interviews in the original source language (Afrikaans). I did the first stages of analysis in Afrikaans. Thereafter I used machine translation (Google translate) to translate the interviews from the source (Afrikaans) to the target language (English). I then re-read each interview word for word and made sure the sentences were constructed correctly and true to the original meaning. I then used back translation as mentioned by Van Nes *et al.* (2010) to ensure that the translation conveyed the original meaning as it was expressed in the source language. It is in the translation of quotations from Afrikaans to English that the translation might interfere with the meaning. I guarded against this while translating by staying close to the original meaning. I am bilingual (Afrikaans and English) and I also used an external bilingual person to verify the data analysis process.

### 2.5.5 Data analysis

Data analysis is the technique used to reduce, organise and give meaning to the data collected. Qualitative data analysis tends to be inductive and involves the transformation of data (that are text) into findings (Polit & Hungler, 1993). Van Manen (1997) suggests that it is necessary for the researcher to acknowledge his or her previous experience, knowledge and beliefs and how these may influence the research in all phases of data collection, analysis and interpretation. A journal of personal reflections on the interviews, as well as my perceptions and thoughts throughout the study, was kept to reflect on my own experiences as a cancer survivor. While these observations are not actual data, they have been valuable in the process of interpretation of the data (Greene, 2009).

The data analysis method proposed by Van Manen (1984), combined with the method provided by Tesch (1990), were used. Van Manen (1984) recommends that both the highlighting and line-by-line approach should be used if possible when uncovering themes. To aid the process of identifying patterns or similar ideas relevant to the participants' experiences and perspectives, this study also used an open-coding system to analyse participant's responses line by line, phrase by phrase and word by word (Creswell, 2003).

The methods that Van Manen (1984) and Tesch (1990) proposed are both thematic in nature. The integrated thematic analysis (Tesch and Van Manen) is suitable within the hermeneutic phenomenology approach, as the purpose of themes is to give structure to the experience (Van Manen, 1990).

The following steps suggested by Tesch (1990) directed me in the hermeneutic phenomenology data analysis process:

1. After the interviews had been transcribed, the transcriptions were read through repeatedly.
2. The most interesting interview was selected and carefully read through again, with the researcher making notes of thoughts in the margin.
3. This was done with all the other interview transcriptions and then a list of key words was compiled.
4. Key words with similar meanings were clustered together into topics.
5. The topics were abbreviated as codes and written next to the appropriate parts of the text.
6. The most descriptive wording was found for each code and from that themes were created by clustering meaning-related codes together.
7. A final decision was then made on the labelling for each theme.
8. The grouping of the material within the themes was then done based on a reflection on how the themes related to one another and to the research phenomenon.
9. Lastly the data were recorded and the findings were reported.

I concluded these steps in the following two phases, namely from immersion into the data to the development of themes and finally in developing comprehensive understanding.

#### 2.5.5.1 *From immersion into the data to the development of themes*

I repeatedly listened to the recording of the interviews and transcribed them. Then I read and re-read the transcriptions. When necessary, I listened to the corresponding recording again to ensure accuracy of the transcription and a better overall understanding of each participant's experience (Van Manen, 1984). I looked at each sentence and asked, "What does this reveal about the cancer survivor's lived experience when he/she returned to the workplace?" The selective or highlighting approach (Van Manen, 1990) was then used by highlighting or underlining significant and revealing statements, sentences or quotations that would help me understand how the participants experienced returning to work after treatment. Below is an example of such a statement:

*Look, what happened, my metabolism got mixed up after the chemo. I gained weight and then I lost weight. I got tired (P1).*

In the initial analysis, this quotation was highlighted and linked with keywords such as, "metabolism problems, weight gain/loss, tiredness" and to the concept "physical symptoms", which was later coded as "physical". This led to the sub-theme of "physical challenges" and to the theme, "physical, psychological and psychosocial challenges that influence cancer survivors in their work". The process of identifying similar concepts was repeated with each of the eight interview transcripts and codes were written alongside the transcripts (compare Harding, 2013). Key words and concepts that were found to be common between the interview transcripts were then grouped together in table form (as recommended by Harding, (2013) and Miles and Huberman (1994). This was then used as the basis of development of subsequent sub-themes and themes. At this stage, sub-themes and themes were not concrete, changing many times before clarity was reached (Greene, 2009; Harding, 2013).

#### 2.5.5.2 *Developing comprehensive understanding*

When the themes had been identified, I then began the process of writing the themes and describing how they were interrelated. Reflecting on these descriptions and reviewing the literature to increase my understanding of the text, I continued rewriting and this led to an integrated model that represented the main

themes as a meaningful whole (Greene, 2009; Lindseth & Norberg, 2004; Van Manen, 1984).

## **2.6 TRUSTWORTHINESS**

Guba (1981), suggest four major concerns relating to trustworthiness of naturalistic inquiry, namely credibility (truth value), transferability (applicability), dependability (consistency) and confirmability (neutrality).

### **2.6.1 Credibility**

Credibility or truth value refers to confidence in the findings. Lincoln and Guba (1985) argue that credibility is one of the most important factors in establishing trustworthiness. The following provisions were made to ensure credibility:

- The inquirer will use peer debriefing by exposing her thinking to a colleague to test and redirect thinking where necessary (Guba, 1981, Shenton, 2004). In this study I verified uncertainties with knowledgeable people (my supervisors) but did not use peer debriefing because of the extensive demand on a colleague's time.
- The specific procedures used in data gathering and data analysis are derived from well-known methods (Shenton, 2004). As is evident in the previous section, I applied an integrated analytic strategy, which I derived from van Manen (1984) and Tesch (1990).
- A thick description of the lived experience of the cancer survivor in the workplace is provided (Shenton, 2004). In Chapter 5 I provide verbatim excerpts from the data and all interpretations are grounded in these verbatim participants' narratives, as is seen in Chapter 6.
- Tactics to help ensure honesty in participants when contributing data were employed by giving each person who was approached the opportunity to refuse to participate or to withdraw at any stage. This ensured that only those who were genuinely willing to take part participated. Confidentiality and privacy were also ensured to encourage honest participation (Shenton, 2004). I briefed participants before the interviews took place about their right to refuse

participation or to withdraw at any stage and ensured confidentiality and privacy. These were ensured by protecting the participant's identities by referring to them as participant P1, P2, etc.

- The conducting of a literature study throughout the study to relate the research to past studies and evaluate it in that context (Shenton, 2004, Silverman, 2005). I did a literature study before the study to search for relevant research on cancer survivors' experience when they returned to work and during the interviews I reviewed the relevant aspects of the experience as these emerged. During the analysis phase I searched for more information to review and reflected on the emerging themes and in the writing of the results and conclusions I again reviewed the literature to evaluate and related it to previous studies.

### **2.6.2 Transferability**

Transferability or applicability shows that the findings have applicability in other contexts. Lincoln and Guba (1985) suggest that it is the responsibility of the researcher to ensure that sufficient contextual information about the fieldwork sites is provided to enable readers to relate the findings to their own positions. Shenton (2004) also mentions that information on the boundaries of the study should be supplied. I used the following methods to promote transferability:

- A thick description of the phenomenon under investigation is given to allow readers to have proper understanding of it so that they are able to make a transfer. This is particularly evident in the background and contextual sections in Chapter 1.
- Rich descriptions of the data in the findings of the research are given to give the reader a meaningful account of the phenomenon.
- Purposive sampling was used to ensure that maximum number of relevant experiences were shared.
- Information regarding the boundaries of the study are given throughout Chapters 1 and 2 by supplying the following, as suggested by Shenton (2004):

- a) the number of organisations that took part in the study and where they were based;
- b) restrictions on the type of participants who contributed to the data;
- c) the number of participants;
- d) the data collection method that was used;
- e) the number and length of the interview sessions.

### **2.6.3 Dependability**

Dependability or consistency shows that the findings are consistent and could be repeated. Lincoln and Guba (1985) stress the close ties between credibility and dependability, stating that a demonstration of the former goes some distance in ensuring the latter.

In this study the following methods were employed to ensure dependability:

- Establish an audit trail – a running account of the research process was outlined (see Table 2.1) to describe what was planned and executed (as suggested by Shenton, 2004).
- In-depth methodological description (the research design and its implementation) was provided in Chapters 1 and 2. This would allow the study to be repeated (Shenton, 2004).

### **2.6.4 Confirmability**

Confirmability or neutrality refers to the extent to which the findings of the study are shaped by the participants and not researcher bias, motivation or interest (Guba, 1981). Confirmability is the qualitative researcher's comparable concern with objectivity (Shenton, 2004). Here steps are taken to ensure that the study's findings are the result of the experiences of the cancer survivors, rather than the preferences of the researcher (Shenton, 2004). The following were applied to ensure this:

- I practised reflexivity by keeping reflective notes throughout the study, as proposed by Guba (1981).

- I was transparent about my beliefs and assumptions (see Shenton, 2004) and reflected continuously on how these affected my decisions and interpretations in this study.
- The use of an audit trail allows any observer to trace the course of the research via the decisions made and procedures described (Shenton, 2004).
- I admitted shortcomings in the study's methods and their potential effects (see Shenton, 2004).
- An in-depth methodological description was given, as proposed by Shenton (2004), to allow the integrity of research results to be scrutinised.

## **2.7 ETHICAL CONSIDERATIONS**

In Chapter 1, paragraph 1.7, the ethical considerations applicable to this study were discussed. In summary, the principles of beneficence, autonomy, beneficence and justice are mentioned.

Firstly, participants will not be harmed, thus supporting the principle of *beneficence*. I foresaw that the possible consequences of this study could be emotions that went with the sharing of the participants' experience of illness. I tried to address this by giving them access to the social worker at Oncology. They all agreed voluntarily to participate and it was mentioned to them that they were free to withdraw from the study at any stage without giving any reason. It was also mentioned (to participants who became very emotional) that the social worker at the oncology division was available, should they require further counselling. I was prepared, if I sensed that the interview was causing issues to surface that might cause emotional trauma to participants, to end the interview or schedule a follow-up counselling referral with the social worker at Oncology (Streubert & Carpenter, 2011).

The principle of *autonomy* was supported by asking the participants to sign an informed consent form enabling me to use the information for research purposes and publication. Participation was voluntary. Any participant had the right to decline/withdraw his/her participation in this study at any stage (Mouton, 2001).

The information provided in the interviews was treated with care and compassion. All information was treated as confidential.

The principle of *beneficence and justice* was upheld by demonstrating professional integrity and objectivity (Streubert & Carpenter, 2011). The protection of the participants' rights was maintained at all times. I respected the participant's self-esteem and dignity at all times.

Further to these considerations, the four guidelines for directing research as proposed by Denzin and Lincoln (2011) are informed consent (as already discussed), deception, privacy and confidentiality (briefly discussed) and accuracy.

### **2.7.1 Informed consent**

The participants were individually informed, before the interviews took place, about the nature of the study and the possible consequences. The potential benefit of participating in this study was to create greater awareness of the possible challenges that the cancer employee faces at work and it might lead to interventions that could improve the situation for cancer survivors. The participants were also made aware that they might request a summary of the findings of the study.

### **2.7.2 Deception**

Denzin and Lincoln (2011) mention that some information cannot be obtained without at least deception by omission. "The standard resolution for this is to permit a modicum of deception when there are explicit utilitarian reasons for doing so" (Denzin & Lincoln, 2011, p. 65). The full explanation of one's purpose would overwhelm the listener. In this study it was not necessary to deceive any participant, as the purpose of the study was clearly to share in the lived experience as perceived by the cancer survivor and this information was shared freely.

### **2.7.3 Privacy and confidentiality**

The participants' identities were protected by referring to them as P1 – P8 (participants one to eight). All the personal data were secured and will only be made available "behind a shield of anonymity" (Denzin & Lincoln, 2011, p. 66).

It was important to limit data collection to information essential to the topic under study. In this study participants shared a lot of private, emotionally laden informa-

tion with me and according to Harding (2013), I had to distinguish between what was essential to the study and could best be omitted. I also made a participant information sheet available to all the participants in which I mentioned the purpose of the study, why they were invited to participate, the nature of their participation and what the research involved, withdrawal from the study, the potential benefits of taking part in the study, the anticipated inconvenience of taking part in the study, confidentiality, how the information would be stored and ultimately destroyed, ethical approval for the study and how they would be informed of the findings.

Hard copies of the information will be stored in a filing cabinet at my home for future research or academic purposes; electronic information will be stored on a password-protected computer. All of these will be stored for a period of five years, whereafter it will be destroyed by putting hard copies through a shredder and permanently deleting electronic information.

#### **2.7.4 Accuracy**

To assure that data were accurate, the principle of trustworthiness as discussed above was employed. The methods described in section 2.6 were used to ensure the accuracy of the findings, as suggested by Denzin and Lincoln (2011).

## **2.8 REPORTING**

In the findings to follow, a qualitative reporting style is used in which each of the major themes that emerged from the data is described separately. Participants' experiences of each of the major themes are presented and discussed. The participants' verbatim responses are also given to illustrate their responses, as well as for use in more complex themes, which may require some further explanation. Minor modifications involving the omission of words were made to some of the interview excerpts without affecting meaning, in order to achieve compactness and assist with reader understanding (De Vos, Strydom, Fouché & Delpont, 2005). The identified major themes were categorised by referring to the research questions and sub-themes were identified as supporting to the major themes (Braun & Clarke, 2013).

A critical hermeneutical reflection against the literature followed the structural analysis and resulted in a model that incorporates the individual and organisational perspective on the various influences involved in supporting the cancer survivor to maintain wellbeing on RTW. Phases and themes of adjustment/coping and organisational support were also identified.

## **2.9 SUMMARY**

In this chapter the research design and method were discussed. A qualitative research design was used. The research methods were also elaborated. This included the sample data collection and data analysis. The trustworthiness, ethical considerations and reporting of the research findings were also discussed. In the following chapter the wellbeing of an employee with cancer will be discussed from a theoretical perspective in terms of organisational functioning.

# CHAPTER 3

## WELLBEING OF THE EMPLOYEE WITH SPECIFIC REFERENCE TO THE CANCER EMPLOYEE

### 3.1 INTRODUCTION

The wellbeing of employees is in the best interest of communities and the workplace. The workplace is a significant part of a person's life that affects one's life and the wellbeing of the community. However, the wellbeing of employees is also in the best interest of employers who try to generate products and profits and retain customers (Harter, Schmidt & Keyes, 2002).

Employees (or human capital) are the most valuable asset of organisations because organisations compete for business through the people they employ (Weatherly, 2003). Organisational value comprises three major classes of assets, namely financial, physical and intangible assets. Human capital is an intangible asset. Human capital is the only intangible asset that can be influenced, but never completely controlled. It is therefore to the organisation's advantage to ensure that its greatest assets, namely employees, are maximally engaged (Weatherly, 2003).

In Chapter 2 the research methodology is described and the participants are introduced. In this chapter the wellbeing of the employee in the workplace will be discussed with specific reference to the cancer employee.

### 3.2 WELLBEING IN THE WORKPLACE

Wellbeing is described as a person's experience of life (including job-related experiences), specifically self-reported happiness and perceived life satisfaction (Danna & Griffin, 1999).

Studies suggest that the emotional wellbeing of employees and their satisfaction in the workplace affect citizenship at work, turnover rates and performance ratings, which may be in the best interest of the employer (Harter *et al.*, 2002). In the past two decades, organisations have become increasingly aware of the relationship between an employee's wellness and productivity (Hillier, Fewell, Cann &

Shephard, 2005; Keyes, Hysom & Lupo, 2000; Marx, 2011). Individual wellbeing or wellness<sup>2</sup> comprises the various life, non-work satisfactions enjoyed by individuals as well as work, job-related satisfactions and general health (Hillier *et al.*, 2005; Marx, 2011).

Individual wellbeing is influenced by the presence or absence of variables in the environment and will influence how an individual will act or react to situations, either as a stress or coping response. The two principal factors underpinning employee wellbeing are how much control over a situation employees believe they have (perceived control) and various types of support an employee receives from others (social support) (McGuire & McLaren, 2009). It is expected that if employees feel supported in the workplace it will increase their commitment and will be likely to result in higher levels of performance, which will positively affect an employee's wellness. Employee empowerment and participation can also increase an employee's sense of control and improve the employee's health and wellbeing (McGuire & McLaren, 2009). It was found that employees who feel supported in the workplace have higher levels of employee commitment (McGuire & McLaren, 2009).

According to Hillier *et al.* (2005), creating and generating wellness at work involves a balance between healthy performance (which relates to the degree to which a person feels in control of his/her own work and empowerment), a sense of purpose (as defined by the individual, group and organisation), effective and inclusive communication (the connection between the organisation and the individual, and between the individual and work networks) and work-life balance (the balance between work and life).

The wellbeing of the cancer survivor in the workplace will be discussed next in terms of the cancer survivor (personality and health), chronic illness and recovering from trauma theories, the positive psychology perspective exploring subjective wellbeing (SWB), coping adjustment and coping efficacy.

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<sup>2</sup> According to research done by Kirsten *et al.* (2009), 'health', 'wellbeing' and 'wellness' tend to be used interchangeably.

### **3.3 WELLBEING OF THE CANCER SURVIVOR**

The wellbeing of the cancer survivor will next be discussed in terms of certain personality traits and affective dispositions, whereafter a discussion will follow about the health of the cancer survivor in the workplace and finally theories about chronic illness and recovery from trauma will be highlighted.

#### **3.3.1 Personality and affective dispositions of a cancer employee**

According to Hoffman *et al.* (2013), personality traits and dispositional variables (self-beliefs) play important roles in people's reactions to negative events and trauma. Certain traits may affect how people appraise life events, perceive their coping efficacy and manage coping strategies (Lent, 2004). Hoffman *et al.* (2013) found that the most studied personality factors in cancer survivorship research included optimism, positive and negative affect and generalised self-efficacy (GSE), which will be discussed next.

Dispositional optimism is defined as a global expectation that more good (desirable) things than bad (undesirable) ones will happen in the future (Scheier & Carver, 1985). Optimism has been associated with increases in positive psychosocial and health behaviours, higher levels of social support and emotional wellbeing and physical and psychological functioning (Hoffman *et al.*, 2013). Optimists tend to have positive attitudes and are inclined to use more appropriate coping strategies (Conversano *et al.*, 2010).

Positive affect is defined by Cohen and Pressman (2006) as feelings that reflect a level of pleasurable engagement with the environment. Clark, Watson and Mineka (1994) define negative affect as a temperamental sensitivity to negative stimuli resulting in feelings of fear, anxiety, depression, guilt and self-dissatisfaction. Hoffman *et al.* (2013) report that positive and negative affect seem to act as separate constructs. Positive changes, such as positive reappraisal and goal re-engagement, are related to greater positive affect, whereas negative changes (e.g. avoiding coping) are related to both greater negative affect and less positive affect. The role of positive emotions in SWB will be discussed in paragraph 3.4.1, as there are similarities between certain personality traits and SWB components.

GSE refers to the global confidence that a person has in his/her capabilities across life contexts (Hoffman *et al.*, 2013). Studies have shown that higher levels of GSE are associated with the use of an active coping style and higher levels of emotional wellbeing (Hoffman *et al.*, 2013). GSE is thus important to cancer employees, as it might help them in identifying coping strategies that will be effective for dealing with their cancer (Hoffman *et al.*, 2013).

### **3.3.2 Cancer survivors and their health in the workplace**

According to Steiner *et al.* (2008), several studies have shown that most cancer survivors RTW in the same capacity as before the cancer treatment. Determinants of RTW include the type of cancer, characteristics of the job and the persistence of cancer or treatment-related symptoms. Kennedy *et al.* (2006) mention that work provides a social connection and enables the cancer survivor to regain a sense of normality and control. RTW may enhance the cancer survivor's quality of life and may be seen as a symbol of recovery (Steiner *et al.*, 2004).

According to Main, Nowels, Cavender, Etschmaier & Steiner (2005), the effects of cancer and cancer treatment on cancer survivors may influence their ongoing health, which may have an impact on their work experience (functional health), overall health issues such as fatigue and pain (physical health), psychological and emotional aspects (mental health) and short-term memory deficits (cognitive health). Hoffman (2005) reports that whether the cancer survivor's diagnosis or treatment will result in working limitations depends on factors such as age, type of cancer, financial status, education, access to health care, the physical demands of the job and the presence of any other chronic health conditions (co-morbidities). She uses an example of cancer survivors in physically demanding jobs who have higher disability rates than those in sedentary jobs. She also reports that research has shown that cancer has a greater impact on survivors' physical than mental capabilities.

According to Manicom (2010), the reported challenges for survivors in a work environment are adjustments to changed appearance with possible body image issues, altered body functioning, uncertainty about resuming employment (e.g. fatigue, workload), disruption or interruption of career path, potential prejudice when returning to the workplace (particularly when seeking new employment),

possible psychological disorders (e.g. depression and/or anxiety and sometimes post-traumatic stress disorder [PTSD]) and uncertainty about personal life expectancy. These challenges make future planning difficult for the cancer survivor and causes emotional exhaustion (Manicom, 2010).

According to Brannon and Feist (2004), adaption to an illness is not easy. A chronic illness changes people's perception about themselves (self-perception). Chronic illness forces survivors to re-evaluate their lives, relationships and perceptions about their bodies. People experience that their lives will never be the same again. Some adjustments are required that may relate to physical functioning or appearance, be linked to capacity for economic activity or lead survivors to review their world views and values (Manicom, 2010). When people fall ill, they often change their behaviour and relationships and their expectations may also change. Many patients experience emotional distress, fear, anxiety, irritability, feelings of helplessness and hopelessness, changes in their relationships with spouses and other family members or a combination of these conditions (Brannon & Feist, 2004). It is a challenge for people who are ill to maintain relationships. Therefore it will also have an impact on the cancer survivor's relationships at work.

In Chapter 1, the factors that have an impact on work after a cancer diagnosis were discussed and various physical and cognitive impairments were mentioned. Added to these, the stigma attached to cancer is another problem. Chapple, Ziebland and McPherson (2004) stated that any diagnosis of cancer can be associated with fear and stigma. This may be because the cause of cancer is not always understood and it is often seen as a death sentence. Ignorance and perceptions among fellow employees about the nature and prognosis of cancer often create a feeling of pity or exclusion of the cancer survivor (Mitchell & Bruen, 2008).

From the above it is clear that cancer has an impact on the cancer employee in various ways. It will therefore require effort from cancer employees themselves and others at the workplace to make a successful RTW (Varekamp et al, 2009).

### **3.3.3 Chronic illness and recovery from trauma**

The following theories were relevant in studying the cancer survivor's lived experience on RTW. The first one I would like to mention is recovery from the

trauma process (McGrath, 2001). McGrath (2001) proposes that recovery from trauma entails the following phases: circuit-breaking, return of feelings, constructive action and reintegration. She describes circuit-breaking as a period when a person feels numb and in shock. When their feelings return, people work through it by telling their story. People then need to take action to restore a sense of control and in the reintegration stage learning and growth take place and meaning is incorporated in a person's life.

Fennell (2012) refers to the four phases of chronic illness as crisis, stabilisation, resolution and integration. She prefers the term phase rather than stage because stages imply a progression that only moves forward. Phase implies that one is likely to be thrown back into earlier phases when new and unforeseen crises occur in one's life. The changes occur in a persons' physical, psychological, social and work life. In the first phase, crisis, a person moves from the actual onset of the illness to an emergency stage, which results in the seeking of some kind of relief. In the second phase, stabilisation, a plateau of symptoms has been reached. A person keeps on trying to find a way to return to the old life before the illness. The task is to begin to stabilise and restructure life patterns and perceptions. In the third phase, resolution, a person realises that he/she cannot be the person that he/she used to be before the illness. The task is to develop a new, authentic self and to find a meaningful philosophy to live by. In the fourth phase, integration, a person is able to integrate parts of the old self from before the illness with the person they have become. The task is to continue to find ways to reintegrate or form new supportive networks, to find appropriate employment or other vocations or activities and to position the illness experience within a larger philosophical or spiritual framework. In total integration, a person "arrives at a new, whole, complete life, of which illness is only one part" (Fennell, 2012; p3). These four phases are comparable to the four stages of trauma (McGrath, 2001) mentioned above, i.e. circuit-breaking (crisis), awakening (stabilisation), constructive action (resolution) and reintegration (integration).

These stages or phases serve as guidance from the literature as to what needs to be considered in the present research.

### **3.4 SUBJECTIVE WELLBEING**

SWB refers to a person's perceptions and evaluations of life in terms of one's wellbeing (Bakker & Oerlemans, 2011; Diener, 1984; Hou & Lam, 2013). Subjective means that which people feel and report, "based on or influenced by personal feelings, tastes, or opinions" (Oxford dictionaries online). Wellbeing means "the state of being comfortable, healthy, or happy" (Oxford dictionaries online). Thus if the two meanings are added together, SWB is a person's feelings or opinions of one's own life in terms of one's state of being comfortable, healthy, or happy.

Bakker and Oerlemans (2011) apply Diener, Sandvik and Pavot's definition of SWB to the workplace, saying that employees have high work-related SWB if they are satisfied with their jobs and experience frequent positive emotions and infrequent negative emotions. Bergh and Theron (2009) mention that SWB consists of positive affect and satisfaction with life. Positive affect was already explained in paragraph 3.3.1 with reference to personality traits and is further associated with psychosocial and behavioural factors such as social connectedness, perceived social support, optimism and preference for adaptive coping responses, as well as greater likelihood of performing health behaviours (Cohen & Pressman, 2006; Diener & Chan, 2011). Satisfaction with life refers to a judgemental process in which one evaluates one's life condition regarding to one's own subjective standard (Hou & Lam, 2013). Bergh and Theron (2009) propose that SBW is associated with various aspects of a person's subjective experience and evaluation of the quality of life, as well as the quality of emotional, psychological and social wellbeing.

Thus emotional, psychological and social wellbeing will be explained next.

Emotional, or affective wellbeing, is a person's evaluation of his/her happiness and life satisfaction, as well as the higher ratio of positive affect over negative affect (Bergh & Theron, 2009). According to Ryff (1989), psychological wellbeing refers to the more lasting life challenges, such as having a sense of purpose and direction, having satisfying relationships with others and reaching a sense of self-realisation. Ryff and Singer (1996) described six qualities that explain psychological wellbeing:

- Self-acceptance (this type of person has a positive attitude about him/herself)
- Personal growth (this type of person experiences his/her life as a continuous process of openness to the need for development, change and growth)
- Purpose in life (this type of person has direction in life and focusses on achieving goals)
- Environmental mastery (this type of person feels competent to manage his/her environment)
- Autonomy ( this type of person is self-determining and acts out of his/her own free will)
- Positive relations with others (this type of person is able to form warm, satisfying, trusting and sharing relationships with others)

Keyes (1998) suggests that social wellbeing consists of five facets, namely *acceptance*, *actualisation*, *coherence*, *integration* and *contribution*, which will be explained next.

Individuals who illustrate *social acceptance* trust others and believe that people are kind despite their displays of complicated behaviour at times.

*Social actualisation* is the evaluation of the potential and the movement of society. This type of person believes that society has the potential to grow positively and realises that potential by helping it to become a better place for everyone.

*Social coherence* is the perception of the quality, organisation and operation of the social world, including concern for knowing about the world. This type of person experiences the community as logical and predictable.

*Social integration* is the evaluation of the quality of one's relationship to society and community. This type of person feels part of and supported by the community, as well as sharing commonalities with the community.

*Social contribution* is the evaluation of one's social value. This type of person thinks that he/she has something valuable to give to the community and that the community values this contribution.

Why then is SWB important in this study of the cancer employee? It is firstly important, as Bergh and Theron (2009) state, because employees who experience

high levels of wellbeing and positive emotions deal better with stressors at work, have higher levels of job satisfaction, display positive interpersonal relationships in the work context and make greater contributions to organisational effectiveness. Secondly, as Keyes, Hysom & Lupo (2000) argue, as employee wellbeing increases, the productivity and profitability of the organisation also tend to increase.

Given the important role of positive emotions in SWB, this will be discussed next.

### **3.4.1 The role of positive emotions in subjective wellbeing**

Research has confirmed the role of positive emotions in the experience of subjective psychological wellbeing. Positive emotions serve as markers of optimal wellbeing (Fredrickson, 2001). Positive emotions include emotions such as feelings of wellbeing, happiness, joy, interest, contentment and love (Bergh & Theron, 2009). People's positive and negative emotions have been shown to predict their judgements of SWB (Fredrickson, 2001). Positive emotions act as a means of restoring and enhancing emotional wellbeing and are a useful response for coping (Bergh & Theron, 2009).

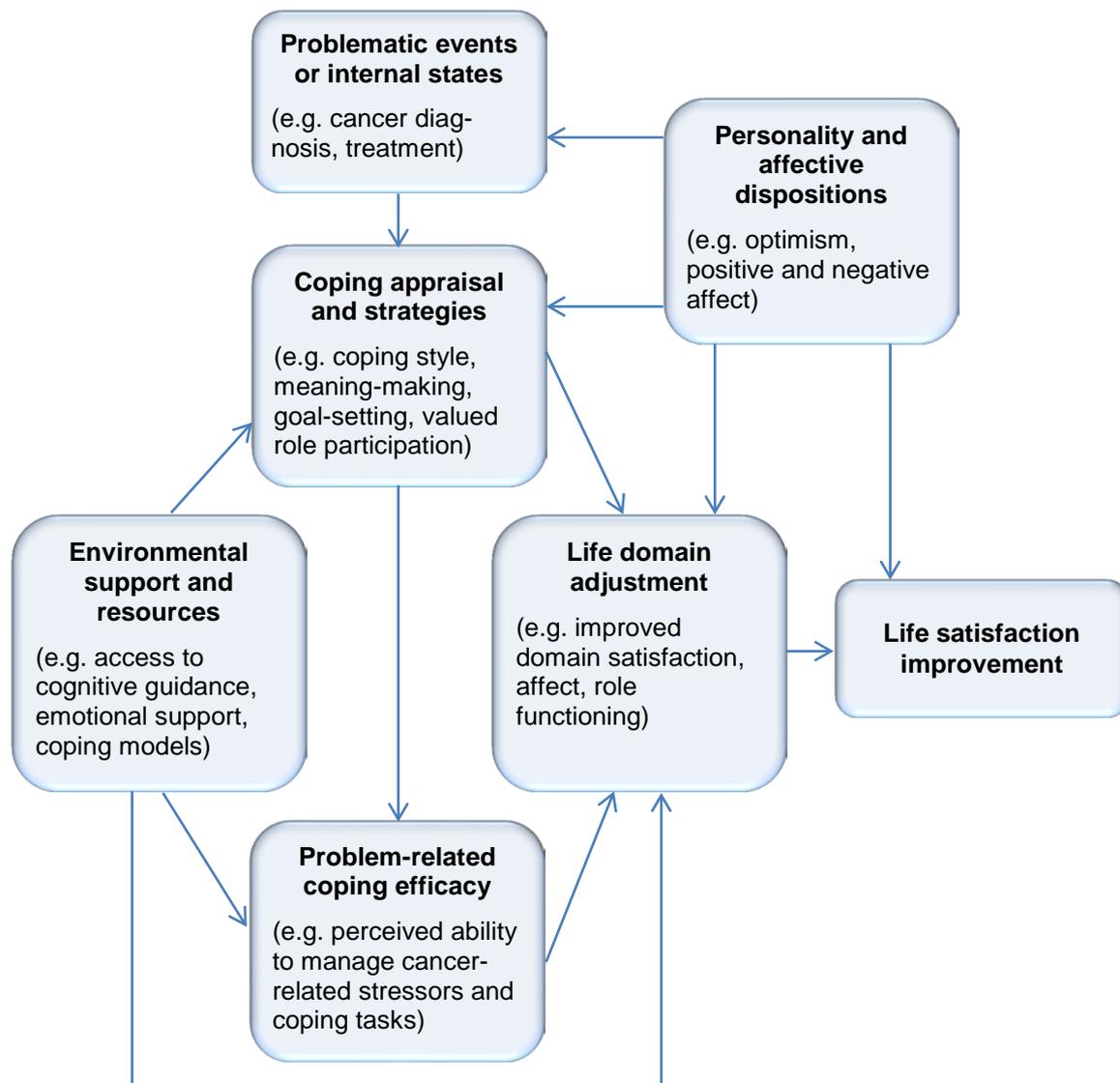
Fredrickson's broaden-and-build theory explains how positive emotions and affect broaden people's reactions to daily situations and how they allow people to build resources to deal with these daily situations. Through positive emotions people are interested in what is happening around them (Fredrickson, 2001). Fredrickson (2001) further explains that positive emotions help both the body and the mind to regain a sense of flexibility and equilibrium after the impact of negative emotions. According to Strümpfer (2006), the three variables or constructs that contribute to positive emotions are humour (laughter), optimism and gratitude. Humour and laughter encourage positive feelings in one's life, as well as allowing one to move away from a distressing situation. Optimism allows a person to look positively towards the outcomes of one's actions in the future (Bergh & Theron, 2009; Carver, Smith, Antoni, Petronis & Weiss, 2005). Carver *et al.* (2005) predict that optimism will predict better wellbeing in the long term. According to Strümpfer (2006), gratitude is when a person recognises kindness and generosity from others, as well as from a higher power. People who have a high degree of positive emotionality also seem to perceive, think and act in ways that lead to positive emotional experiences (Strümpfer, 2006).

Positive emotions in SWB are important for employees with cancer, as they serve as a means of restoring physiological resources that have been reduced by distress (the illness), encourage cognitive broadening and flexibility, enhance emotional wellbeing and develop coping strategies for handling possible present and future difficulties (Bergh & Theron, 2009).

### **3.4.2 The model of restorative wellbeing**

Lent (2004) presented two models of SWB. The normative model focussed on how employees maintain their sense of wellbeing under normative life conditions and the model of restorative wellbeing entailed how employees restore emotional equilibrium when confronted with particularly stressful conditions. The model of restorative wellbeing is thus relevant to research on cancer survivors' coping process (Hoffman *et al.*, 2013). The model, shown in Figure 3.1, attempts to integrate a number of factors that have been linked to coping and emotional recovery. It begins with awareness of a stressor and includes the coping strategies, efficacy beliefs, personality factors and environmental supports that may influence psychosocial adjustment.

In applying the model of restorative wellbeing, the assumption is made that the process through which people normally maintain their sense of wellbeing may change when they are confronted by problematic external events (e.g. health threats) or internal states (e.g. mood states). The problematic events lead to a coping process that involves appraisal of the threat and the utilisation of coping strategies to protect and optimise one's wellbeing by minimising the threat (Hoffman *et al.*, 2013; Lazarus & Folkman, 1984).



**Figure 3.1:** A model of restorative wellbeing, showing the interrelations of personality, affective and social cognitive variables in the coping process

(Source: Hoffman *et al.*, 2013, p. 245, adapted from Lent, 2004)

### 3.5 COPING ADJUSTMENT FROM A POSITIVE PSYCHOLOGY PERSPECTIVE

Coping has its origin in the salutogenesis approach with the focus on GRRs (see Chapter 1) that people use for coping (Morgan, Davies & Ziglio, 2010). When people experience the frequent availability of these GRRs, a strong SOC develops (Van Wijk, & Waters, 2008). SOC (see Chapter 1) is one of the key concepts of the salutogenic model, but other positive psychology construct may each play its part in mediating coping. According to Strümpfer (1990), a person with a strong SOC will make cognitive sense of the workplace, perceive work as consisting of experiences that are bearable and will make emotional and motivational sense of

work demands. High levels of SOC present more positive experiences regarding how individuals perceive and perform in the work context.

Support for the contribution of the positive psychology constructs proposed for this study can be found in Fredrickson's broaden-and-build theory. Fredrickson's research supports the notion that positivity broadens a person's thoughts and actions, undoes negative emotions, builds psychological resilience and leads to enhanced emotional wellbeing (Fredrickson, 2001). The positive psychology constructs, LOC, self-efficacy, hardiness, potency, LR, optimism, hope, humour, resilience, religion and meaning-making have already been defined in Chapter 1, paragraph 1.5.3.3, in terms of their importance for the description of wellbeing. These constructs will, however, be discussed further regarding their impact on the job performance and desired work attitudes of cancer survivors in order to maintain their wellbeing.

Individuals who believe that they can control what happens to them have an internal LOC and those who tend to think that what happens to them can be attributed to fate, have an external LOC. Those with an internal LOC have a lower rate of absenteeism because they believe that health is for the most part under their control, so they take more responsibility for better health behaviour and are also more active in searching for information before making decisions (Robbins, Judge, Odendaal & Roodt, 2009). Spector (1982) suggests that LOC is related to motivation, effort, performance, satisfaction, perception of the job, compliance with authority and supervisory style. Knowledge about an employee's LOC orientation is thus important for managerial and development purposes.

Self-efficacy affects learning and performance in the workplace in three ways (Bandura, 1982): it influences the goals that employees choose for themselves, it influences learning as well as the effort that people put into the job and it influences the tenacity with which employees attempt new and difficult tasks. High self-efficacy is associated with greater effort and perseverance to cope with obstacles (Bandura, 1977) and thus promoting well-being.

Hardiness is a personality construct that moderates stress-health relationships and consists of three components: a person's commitment to a task, a person's control over the events of his/her life and a person's perception of change as an

opportunity for development (Strümpfer, 1990). Research indicates that developing individuals' hardiness may lead to higher levels of performance and a better ability to deal proactively with stress, and may help employees to be more resilient (Maddi, 2006; Maddi & Khoshaba, 2005).

Potency will enable the individual to restore balance in a situation where the resources at his/her disposal are insufficient for meeting certain demands (Coetzee & Cilliers, 2001). A person with strong potency will be emotionally more stable, less affected by occasional failures in coping and less affected by specific resource shortages (Ben-Sira, 1985). Ben-Sira (1985) also mentions that weak potency is an outcome of unsuccessful coping experiences in the past, which refers to Seligman's term "learned helplessness". According to Ben-Sira (1985), potency fulfils a stress-buffering function.

LR entails an individual's learned behaviours and skills that are used to self-regulate or control his/her behaviour (Bergh & Theron, 2009). As stated by Cilliers and Ngokha (2006), LR is not a personality characteristic, but rather a set of complex behaviours that is in constant interaction with one's physical and social environment. It is brought about by situations that call for self-control and self-regulation and provides the basis for further learning.

Strutton and Lumpkin (1992) and Malik (2013) found that optimistic individuals used more problem-focussed coping strategies in the working environment, resulting in a greater number of positive psychological and work-related outcomes. Malik (2013) mentioned that optimism had a positive impact on physical and psychological health, which in turn led to occupational success.

Malik (2013) also reported that there is a direct work relation between hope and work in that employees with higher hope experience higher satisfaction and commitment. Wandeler, Lopez and Baeriswyl (2011) report that hope is linked to employee satisfaction, commitment, creativity and performance. There is also a positive relationship between hope and psychological wellbeing. According to them, employees with high hope cope better with problems and stressors at work. Snyder and Feldman (2000) suggest that work environments promote hope when employees can gain satisfaction in performing tasks well.

Humour is a common element of human interaction and therefore has an impact on work groups and organisations. People use different humour styles for various reasons. Romero and Cruthirds (2006) report that humour reduces dysfunctional stress, in other words joking about a stressful event makes it less threatening. Managers can use humour to reduce stress and enhance leadership, group cohesiveness, communication, creativity and organisational culture (Romero & Cruthirds, 2006).

According to Malik (2013), resilience is not a trait that people have or do not have. Resilience involves behaviours, thoughts and actions that can be learned and developed in anyone; it is influenced by a person's environment. It is therefore the responsibility of managers to create a workplace that promotes wellbeing and facilitates resilience. Managers must ensure that workplace demands are reasonable and that employees have the appropriate skills and knowledge to deal with the demands they face (Malik, 2013).

Turning to religion might serve as a source of emotional support. According to Rothmann, Jorgensen and Hill (2011), turning to religion is a way of reinterpreting stressful situations in positive terms and dealing actively with stressors. Rothmann *et al.* (2011) also suggest that employees who make use of religion in this positive way are able to maintain high levels of work engagement.

Meaning-making, according to Park *et al.* (2008), is a rebuilding process that is assumed to lead to better adjustment, particularly if sufficient meaning is found or created. I am of the opinion that cancer survivors use benefit-finding (seeking benefits that come out of misfortune), adaptive goal processes (reappraising goals in light of changed circumstances) and reordering of priorities to maintain their wellbeing in the workplace (as suggested by Folkman, 2008).

### **3.5.1 Coping efficacy of a cancer employee**

Coping efficacy is a form of self-efficacy that refers to people's beliefs in their ability to handle particular stressors or obstacles (Bandura, 1997). These beliefs are assumed to affect how people perceive and react to particular unfavourable life events and conditions (Hoffman *et al.*, 2013; Phillip, Merluzzi, Zhang & Heitzmann, 2013). Individuals who possess a high degree of self-efficacy are better able to manage potential challenges or stressors (Bandura, 1991).

If people's perception of their coping efficacy is favourable, they are likely to organise and use the coping methods at their disposal, use environmental supports effectively and persist at problem-solving when faced with difficult conditions (Hoffman *et al.*, 2013). Hoffman *et al.* (2013) found that available data suggested that stronger coping efficacy was related to positive outcomes, such as a higher quality of life and fewer negative emotions.

For the cancer survivor, coping efficacy includes beliefs about one's ability to deal with the various challenges posed by the cancer experience, such as coping with treatment-related side effects, seeking and understanding medical information and obtaining support to manage cancer treatment and recovery (Hoffman *et al.*, 2013).

### **3.5.2 Coping strategies and/or styles for cancer employees**

Coping style consists of a general tendency for a person to deal with a stressful event in a particular way (Taylor, Peplau & Sears, 2003). People implement strategies to cope with appraised stressors. Researchers have found that in general, coping strategies that focus on emotional aspects are associated with poorer emotional adjustment in contrast to those that focus on seeking solutions to problems, which are linked to better adjustment (Šprah & Šoštarič, 2004). Cancer survivors viewed effective coping as strategies that increased hope, did something about the problem, restored balance and used available support systems (Šprah & Šoštarič, 2004).

Four general coping strategies will be discussed in this section: avoidant coping, emotion-focussed coping strategies (efforts to control the emotional consequences of stressful or potentially stressful events) (Lazarus & Folkman, 1984), problem-solving strategies (efforts to do something active to lessen stressful circumstances) (Hoffman *et al.*, 2013) and a meaning-making coping strategy (the recovery of meaning or making new meaning). In a study done by Halstead and Fernsler (1994), they found that cancer survivors chose coping strategies that were optimistic and confrontive in nature and used support systems to minimise the stress of cancer survival. Although social support is not a coping strategy per se, it supports the cancer survivor in the coping process and will therefore also be discussed under this heading of coping.

### 3.5.2.1 *Avoidant coping strategies*

Three coping tendencies that are described as avoidant coping strategies (Carver, Scheier & Weintraub, 1989; Rothmann *et al.*, 2011) are behavioural disengagement (reducing one's effort to deal with the stressor – sometimes identified with terms such as helplessness), mental disengagement (distracting one from thinking about the goals with which the stressors are interfering) and denial (refusal to believe that the stressor exists and acting as though the stressor is not real). Mental disengagement is a variation on behavioural disengagement and occurs via a wide variety of activities (e.g. daydreaming, sleep, immersion in TV) that serve to distract a person from thinking about the stressor (Carver *et al.*, 1989). It is often suggested that denial is useful in that it minimises distress, but on the other hand denying the reality of the event allows the event to become more serious (Carver *et al.*, 1989).

Holahan and Moos (1986) state that avoidant coping strategies seem to be psychological risk factors, or markers, for unsuitable responses to stressful life events. Taylor *et al.* (2003) also mention that avoidant coping strategies lead people into activities (such as alcohol use) or mental states (such as withdrawal) that keep them from directly addressing stressful events.

### 3.5.2.2 *Emotion-focussed coping strategy*

Emotion-focussed coping is a response aimed at reducing or managing the internal aspect of the stressor (Carver *et al.*, 1989; Hoffman *et al.*, 2013). Emotion-focussed coping is designed to alter the person's emotional response and internal stress, rather than to change the situation itself (Krohne, 2002; Manne, 2007). Emotion-focussed coping includes acceptance, positive reinterpretation of the event, distancing, cognitive or behavioural avoidance (denial) and the seeking of social support (Carver *et al.*, 1989; Manne, 2007). For cancer survivors, emotion-focussed coping may help to direct emotional reactions, functional limitations and changes in valued life roles. Positive appraisal strategies, such as viewing the situation as an opportunity to learn from life experiences, have been related to more positive perceptions and redirecting of energy toward new goals when cancer made previous goals unreachable (Schroevers, Kraaij & Garnefski, 2011).

Other positive strategies, including reframing cancer as a challenge, have been positively related to wellbeing and negatively to distress (Degner, Hack, O'Neill & Kristjanson, 2003). Literature indicates that "thinking positively" corresponds with the cancer survivor's overall level of mental health and mortality rates (Šprah & Šoštarič, 2004). However, the "thinking positively" coping style could also represent a stress factor in the cancer survivor. In this case "thinking positively" is not how the person really feels, but rather how people expect him/her to feel (Wilkinson & Kitzinger 2000). Lazarus (1993) found that a coping strategy that produces positive outcomes in one context, or for one person, may not give the same result in another. It is therefore important to consider the context in which coping strategies occur.

#### 3.5.2.3 *Problem-solving coping strategy*

Problem-focussed coping is aimed at practical ways to manage or reduce the stressor (Hoffman *et al.*, 2013; Lazarus & Folkman, 1984). Carver *et al.* (1989) proposed the following as part of problem-focussed coping: active coping (that is the process of taking active steps to remove or reduce the stressor), planning (thinking about ways to cope with the stressor), suppression of competing activities (meaning that other activities are put aside to deal with a stressor), restraint coping (waiting until an appropriate opportunity to act arises) and seeking social support for instrumental reasons (seeking advice, assistance or information).

For cancer survivors, problem-solving coping may comprise gathering information, seeking second opinions and making decisions (Hoffman *et al.*, 2013).

#### 3.5.2.4 *Meaning-making coping strategy*

Meaning-making is another type of reappraisal coping strategy that is defined as the regaining of meaning or making new meaning when facing stressful situations (Park, 2010). Meaning-making results in improved adjustment in different ways, such as acceptance, positive re-evaluation, integrating the experience into one's identity or self-concept or making positive changes in one's life (Hoffman *et al.*, 2013). Lee, Cohen, Edgar, Laizner and Gagnon (2006) suggest meaning-making coping as a possible method to explain the co-existence of positive and negative psychological states following cancer. They further mention that meaning-making following a cancer diagnosis has been linked to a higher level of self-efficacy,

self-esteem and optimism. Searching for meaning, thus, can be considered a broad category of positive coping.

Park (2005) suggested that religion was related to meaning-making coping and to adjustment in terms of subjective well-being and stress-related growth. Turning to religion as a coping response may serve as a source of emotional support or as a method to cope actively with a stressor (Carver *et al.*, 1989).

### *3.5.2.5 Using social support as a coping strategy*

Social support involves a social network, which is an important system of social relationships within the family, relatives, friends and colleagues (Šprah & Šoštarič, 2004). The social environment includes structural and functional measures of support (Helgeson, 2003). Structural measures deal with the basic existence of social relationships. Functional measures refer to the resources that people in an individual's social network provide (Helgeson, 2003). Some of the types of support are emotional support, instrumental support and informational support (Helgeson, 2003; Hoffman *et al.*, 2013). Emotional support refers to having people available to listen and instrumental support refers to people providing concrete assistance. Informational support involves the giving of information, advice or guidance (Helgeson, 2003). Emotional support can lead to improvement of interpersonal relationships, informational support may improve perceptions of control by providing the cancer survivor with valuable information and instrumental support provides concrete assistance in dealing with a stressor (Helgeson & Cohen, 1996).

Helgeson (2003) suggests that the severity of a stressor might indicate which type of support is going to be most helpful. If the stressor is controllable, informational and/or instrumental support may be suitable. If the stressor is uncontrollable, emotional support may be most beneficial. Other distinctions that are mentioned by Helgeson (2003) are between perceived support and received support. Perceived support is the extent to which people believe that support is available to assist them. Received support is when a person actually receives support. Helgeson (2003) reports that perceived support is more strongly related to quality of life than received support. The reason given is that received support (especially

informational support) is associated with greater distress (Helgeson, 2003; Helgeson & Cohen, 1996).

An effective social support system increases self-esteem and decreases depression. Social support is in most cases useful to the cancer survivor (Andrykowski, Lykins & Floyd, 2008; Šprah & Šoštarič, 2004), but on some occasions it might have a distressing effect, i.e. when a person prefers to be alone or in a case when someone has taken control over the person and has broken the balance between support and control. It was also found in research that continuous verbal communication about problems often leads to depression in cancer survivors (Hoffman *et al.*, 2013; Šprah & Šoštarič, 2004). There are other unhelpful behaviours when social support is offered to people with cancer, namely minimising the problem, forced cheerfulness, being told not to worry, medical care being delivered in the absence of emotional support and insensitive comments of friends (Helgeson & Cohen, 1996).

Research suggests that emotional support is viewed most positively by cancer survivors and has the strongest relationship with positive outcomes (Hoffman *et al.*, 2013). In addition to its stress-buffering effects, it is possible that social support may help the cancer survivor to work through this troubling event (Andrykowski *et al.*, 2008; Hoffman *et al.*, 2013).

### **3.6 SUMMARY**

The various psychological and physical issues that face the cancer survivor on returning to the workplace is evident in the literature. Understanding all the factors that influence cancer survivors when they commence work after treatment is important for the facilitation of their wellbeing in the workplace.

In this chapter the impact of cancer on the employee, the coping strategies of the cancer survivor, wellbeing of the cancer survivor in the workplace and SWB were discussed. In the following chapter strategies aimed at facilitating the wellbeing of cancer employees will be discussed.

## **CHAPTER 4**

# **STRATEGIES AIMED AT FACILITATING THE WELLBEING OF CANCER SURVIVORS IN THE WORKPLACE**

### **4.1 INTRODUCTION**

Issues facing cancer survivors in the workplace differ depending on the type of cancer, the severity of cancer-related symptoms and the type of employment (Steiner *et al.*, 2008). The workplace provides support and social connections that may increase cancer survivors' quality of life (Kennedy *et al.*, 2006; Main *et al.*, 2005; Rasmussen & Elverdam, 2008). The ability of employers and employees to discuss cancer and its associated limitations (communication), the support system for survivors and their colleagues, the organisation's resources and policies, management and the design of the RTW process all influence the quality of work outcomes (McKay *et al.*, 2013).

In Chapter 3, the wellbeing of an employee with cancer was discussed. In this chapter strategies aimed at facilitating the wellbeing of cancer survivors will be discussed by means of the following topics: occupational health, cancer survivors and their health in the workplace, employee assistance programmes (EAPs), interventions or strategies to assist cancer survivors in the workplace and the management of the employee with cancer.

### **4.2 OCCUPATIONAL HEALTH**

The discipline of occupational health is concerned with the relationship between work and health. Occupational health is a multi-disciplinary issue that concentrates on the protection of the safety, health and welfare of people engaged in work or employment (Bohle & Quinlan, 2000). The definition and importance of occupational health in the workplace will subsequently be discussed.

#### **4.2.1 Definition of occupational health**

Occupational health is formally defined by Acutt and Hattingh (2011) as:

- Promotion and maintenance of the highest degree of physical, mental and social wellbeing of all workers in all occupations
- The prevention of unfavourable health consequences for workers as a result of conditions in their workplaces
- The protection of workers that are at risk because of existing factors in their places of employment
- The retention of workers in occupational environments that have been adapted to suit their physiological and psychological conditions.

#### **4.2.2 The importance of occupational health in the workplace**

According to Guild, Ehrlich, Johnston and Ross (2001), occupational health is the responsibility of the employer to improve workplace conditions and to prevent illness and disability related to work. Occupational health is important in the workplace through the management of risk, a reduction in business losses and an increase in the ability to meet business objectives.

According to Crafford, Moerdyk, Nel, O'Neill and Schlecter (2006), occupational health focuses on creating a healthy work environment, using consultation to promote and facilitate employee health and using various health promotion interventions in health promotion and disease management.

#### **4.2.3 Implementation of an occupational health programme**

The employer has a responsibility to create a healthy work environment for employees. It requires eliminating carcinogenic exposure in the workplace and giving employees the necessary protection where such exposure is unavoidable (Nadasen, 2000). It is, however, necessary for employees to discuss possible occupational health challenges with their supervisors and reach a solution (Varekamp *et al.*, 2009). In addition, the employer has the responsibility to train, educate and warn employees about the dangers of exposure to certain conditions/materials (Nadasen, 2000). The employer has the responsibility to provide information to employees that can promote their health and to provide consultation to employees regarding their health. Health awareness interventions and promotion of the health of employees in the workplace are important (Nadasen, 2000). Implementation of an occupational health programme could incorporate an

organisational health policy, organising and planning, implementation, monitoring, adjusting and reviewing of the programme (Guild *et al.*, 2001).

If cancer is viewed as a journey, it is clear that the person with cancer, caregivers, and members of the health care team are all co-travellers (Hara & Blum, 2009). In the workplace an inter-disciplinary team works together to implement an occupational health programme effectively. Members of the team may include various people such as a physician, occupational health nurse, employees through their representatives, and other contracted specialised professionals relevant to the occupational health field. The success of the programme ultimately depends on the support of top management (Hatting & Acutt, 2009).

### **4.3 THE RELATIONSHIP BETWEEN CANCER AND WORK**

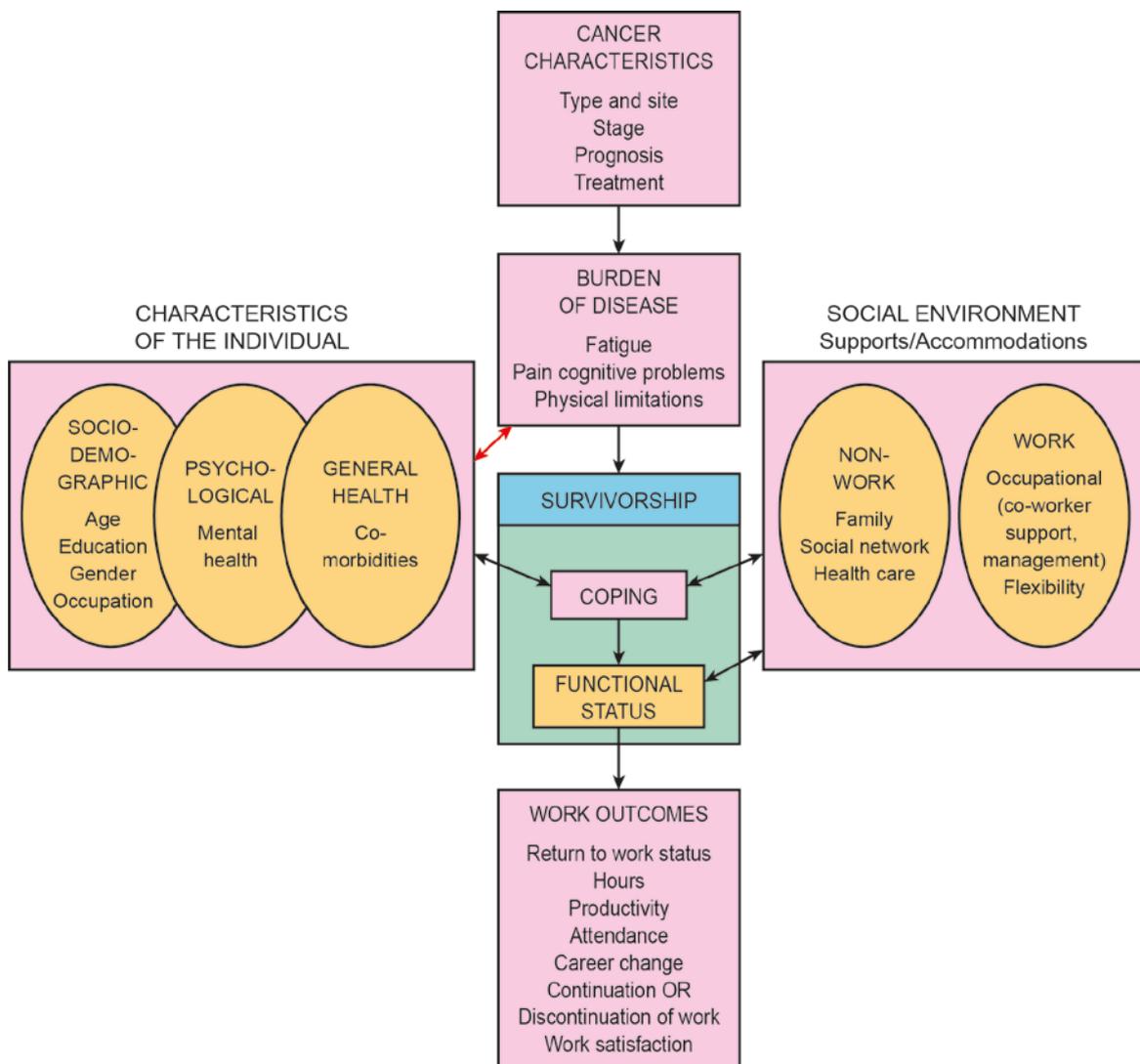
Individuals' experiences at work affect them while they are in the workplace. Workers spend about one third of their waking hours at work. Workers who experience poor health and wellbeing in the workplace may be less productive, may be absent from work more often and may make consistently diminishing decisions and overall contributions to the organisation (Danna & Griffin, 1999). The effects of cancer or the treatment, as well as the emotional adjustment during and after cancer treatment, affect the employee's motivation and his/her functional capacity to do the job, thus negatively influencing the productivity of the employee with cancer (Mitchell & Bruen, 2008).

According to Mellette (1985), the problems that cancer survivors who RTW have to face fall into two categories: those associated with their illness or treatment, and those directly related to the workplace. Mellette (1985) explains that the problems employees who RTW face vary depending on the job and the type of cancer. An example of this is that a person with breast cancer finds it easier to adapt than a person with head and neck cancer. A person with breast cancer can hide the effects of the cancer, whereas a person who received treatment for head and neck cancer, especially where the speech or appearance has changed, encounters other types of problems.

According to Mitchell and Bruen (2008), work is an integral part of our lives and for people with cancer it is the simplest way to feel they are in control in an

uncontrollable situation. Mitchell and Bruen (2008) are further of the view that in most cases, work is the only connection to normalcy for a cancer survivor. A cancer diagnosis is seen as a significant influence on a person's life and way of life. The employer may play a critical role in maintaining hope for these employees. The employee with cancer's attitude to the work may also influence the situation. If an employee does not like the job anyway, the diagnosis may be used as an excuse to stop working. Some people may feel so threatened by the diagnosis that they are afraid to RTW (Mitchell & Bruen, 2008).

Figure 4.1 demonstrates the various influences on the work life of an individual with cancer.



**Figure 4.1:** Relationship between cancer and work outcomes model  
(Source: Nitkin *et al.*, 2011: p.36)

This model suggests that the cancer characteristics lead to physical symptoms (burden of disease) due to the cancer or its treatment, which may in turn affect the functional status of the cancer survivor and ultimately his/her work outcomes. The elements in this sequence of events can be changed by characteristics of the individual and the social environment (support and accommodation) (Nitkin *et al.*, 2011).

From the above there is clear evidence that profitable, productive workplaces are those that enhance the quality of life of employees, which might influence labour turnover, employee commitment and productivity (Hillier *et al.*, 2005).

Next, the various strategies to facilitate the cancer survivor's wellbeing will be discussed.

## **4.4 EMPLOYEE ASSISTANCE PROGRAMMES**

Generally an EAP is a programme that assists employees in dealing with personal difficulties that may be affecting their work performance (Naicker & Fouchè, 2003). According to Attridge (2012), the goal of the EAP is to restore the health and wellbeing of an employee, which will result in an improvement in productivity and in overall organisational performance.

### **4.4.1 Definition of EAP**

According to Els (2006), EAPs were originally introduced in the eighties and provided private and confidential counselling to employees who needed help with disturbing issues, e.g. drug and alcohol abuse, financial problems, stress and trauma and other personal matters. EAP is a professional assessment, referral and/or short term counselling service offered to employees with problems that may affect their work performance (Naicker & Fouchè, 2003).

### **4.4.2 Types of EAP models**

Different types of EAP models are suggested by the literature: the in-house and external or contract model, the consortium model and the hotline model.

#### *4.4.2.1 In-house and external model*

The two main types of EAP models are in-house and external (off-site) models. The in-house model is also called an internal programme, which offers services within an organisation, providing a direct link between the EAP and the employee's workplace. The organisation could also conclude a contractual agreement with an external organisation that offers EAP services, thus making use of an external (off-site) model (James, Braam Rust & Kingma, 2012).

#### *4.4.2.2 Consortium model*

Dessler (1997) explains that a consortium model entails various organisations combining their resources such as finances, personnel and facilities to develop an EAP. An advantage of this model is that smaller organisations can also benefit from the services of an EAP, which they could not normally afford on their own.

#### *4.4.2.3 Hotline model*

The hotline model is a 24-hour telephone service available as self-help for employees. The purpose of a hotline is to refer the employee to an appropriate service provider, who is selected from a directory of service providers, in the employee's area (Nicolaas, 2007).

### **4.4.3 The objectives of EAPs**

According to Rajin (2012), the objectives of EAPs are to conform to statutory obligations and a common law of duty of care by retaining employees by providing support towards their productivity and wellbeing.

### **4.4.4 The principles of EAPs**

The principles of an EAP as suggested by Yende (2005) are confidentiality (maintenance of confidentiality throughout programme), neutrality (counsellors will not side with either management or employees), accessibility (EAP practitioners should be accessible to employees) and voluntary participation (employees should feel free to make use of the EAP services on their own without feeling pressured to do so).

The EAP is designed to provide employees and their immediate families with professional assistance in dealing with a broad range of human relations problems. The wellbeing of the cancer survivor on RTW could be facilitated by using the services rendered by the EAP.

#### **4.4.5 EAPs to assist cancer survivors**

Integrated health promotion interventions are offered under EAPs. According to Bergh and Theron (2009), comprehensive programmes can assist at three levels: organisational health (getting management involvement and support), environmental health (healthy working conditions and efficient workplace design) and individual and group health (assisting employees in various ways to cope with stress or any other problems).

Bergh and Theron (2009) mention that there is now much emphasis on a more positive approach to promote employee and organisational wellbeing in that not only are problems addressed, but optimal functioning is also developed in all employees and the organisation. The facilitation of coping behaviours needs to be aimed at improving positive health behaviours and attitudes in employees. In general, EAPs offer a broad range of services and refer to job-based interventions provided in organisations for identifying the problem, informing and motivating employees, changing attitudes and behaviours and providing or giving access to counselling and treatment for employees (Plaggemars, 2000; Worster, 2000).

According to “An Employer’s Guide to Cancer Treatment and Prevention” (2013), cancer survivors need help from EAPs in assessing how cancer has affected the individual’s psychological wellbeing and identifying the stressors affecting the individual. These stressors can lead to depression and reduced self-esteem, which can negatively affect work performance. It is therefore important to provide support services to the cancer survivor on RTW.

### **4.5 INTERVENTIONS OR STRATEGIES TO ASSIST CANCER SURVIVORS IN THE WORKPLACE**

The reintegration of the cancer survivor into the workplace needs multidisciplinary preparation combined with accommodation from the organisation. Nitkin *et al.* (2011), suggest that there should be integration between clinical interventions

(interventions carried out to improve, maintain or assess the health of a person in a clinical situation) and occupational interventions to improve employment outcomes for the cancer survivor.

#### **4.5.1 Perceived and received organisational support**

Cancer survivors identify the support of employers and co-workers as important in the RTW process (Wells *et al.*, 2013). In discussing the role of the organisation in the RTW of the cancer survivor, it is, however, also important to mention the role of perceived organisational support (POS), which is a central construct in organisational support theory (OST). POS refers to the degree to which employees believe that the organisation values their efforts and cares about their wellbeing (Eisenberger, Huntington, Hutchinson & Sowa, 1986; Shore & Shore, 1995).

OST supposes that employees form a general perception about the organisation's care and consideration for their wellbeing (POS) and they return such perceived support with increased commitment, loyalty and performance (Rhoades & Eisenberger, 2002). Employees view supervisors' attitudes and actions as indicative of organisational support (Eisenberger *et al.*, 1986). In their review of 70 studies, Rhoades and Eisenberger (2002) found that the consequences of POS included increased affective commitment to the organisation, increased performance and reduced withdrawal behaviour.

However, as mentioned in Chapter 3, there is a difference between perceived support and received support (Helgeson, 2003). Perceived support is the extent to which people believe that support is available to assist them. Received support is when a person actually receives support. Organisational support received will therefore help people to talk about and manage challenges, negotiate job-related issues and regain confidence at work.

Vocational rehabilitation (VR) interventions, facilitating empowerment in cancer survivors, and other methods will be discussed as interventions or strategies to assist and support the cancer survivor in the workplace.

#### **4.5.2 Vocational rehabilitation interventions**

VR is a process that enables persons with functional, psychological, developmental, cognitive and emotional impairments or health conditions to overcome

barriers to keep and/or get a job (Coetzee, Goliath, Van der Westhuizen & Van Niekerk, 2011).

VR includes a wide range of interventions to help individuals with health conditions and/or impairment to overcome challenges at work. Examples of these interventions could be assessment of needs, re-training, RTW management by employers, reasonable adjustments, etc. (Ross, 2007). Verbeek, Spelten, Kammeijer and Sprangers (2003) proposed four essential factors related to VR, namely medical knowledge of the disease and treatment, continuity of care, interventions for cancer-related complaints and interventions to improve relations at work.

Coetzee *et al.* (2011) mention the following as part of the vocational rehabilitation process:

Work screening	An interview to assess the employability of individuals.
Work assessment	The purpose is to identify the individual's abilities and limitations and to match or change these to meet the requirements of the job.
Work preparation and work hardening	These processes help individuals to identify and evaluate their abilities, to understand the effects of their health problem on work-related activities, to increase the person's confidence and to establish realistic employment goals. The intention is thus to maximise their ability to return to work.
Work placement	This includes programmes to enable individuals to perform their former work or to prepare them for alternative work. It might also include skills training or retraining.

Hoving, Broekhuizen and Frings-Dresen (2009) state that the rehabilitation needs of cancer patients focus on fatigue, reinforcing physical working capacity and psychosocial functioning. Nitken *et al.* (2011) report that there is a growing population of cancer survivors who have distinct psychosocial and vocational needs. They further state that little attention has been paid to the development of assistance to the cancer survivor with work-related issues.

Nitken *et al.* (2011) also report on a study in the Netherlands involving the provision of an educational leaflet to survivors prior to RTW and treatment plan letters from oncologists, which have shown promising results. They further report on

individualised services that could be beneficial, including vocational counselling, assessment, case management, job search assistance, resource referral and education. Grunfeld *et al.* (2008) mention workplace adjustments, such as changing work duties or the provision of specialist equipment and the need for good communication between employer and employee during the RTW process. Hoving *et al.* (2009) also mention work modifications and case management as beneficial to the cancer survivor. Nitken *et al.* (2011) describe community programmes that aim to address work-related challenges and provide a forum for cancer survivors to share issues with others as helpful. Work-oriented educational sessions can also be offered to survivors to aid them in the RTW process (Nitken *et al.*, 2011). Hoving *et al.* (2009) mention that rehabilitation strategies, for example graded activity (a step-by-step increase in activity), could be beneficial for the cancer survivor to deal with fatigue and functioning. Advice to structure the RTW process and the use of goal-setting during rehabilitation may also be beneficial (Hoving *et al.*, 2009).

### **4.5.3 Facilitating empowerment in cancer survivors**

Empowering cancer survivors is defined as increasing their knowledge and skills to enable them to take personal responsibility for finding solutions for challenges in the workplace (Varekamp *et al.*, 2009). Swift and Levin (1987) use the term empowerment to refer to activities directed at increasing people's control over their lives.

Varekamp *et al.* (2009) mention that social relations in the labour market are different from those in healthcare. This requires a careful interpretation of the empowerment concept. They explain that employers and employees have shared as well as conflicting interests, which could be problematic in the case of the cancer survivor. A conflict of interest occurs when employers require a high level of productivity and workload, whereas employees with a health issue (such as cancer survivors) might prefer a lower workload. The empowerment of individual employees will be useless if the employer ignores or disregards employees with health problems (Varekamp *et al.*, 2009).

Varekamp *et al.* (2009) have developed a vocational rehabilitation training programme with an empowerment approach for employees with chronic diseases.

The training supports the employee in clarifying barriers after which they are encouraged to develop solutions. They mention three important steps in their programme: clarification of problems (exploring and clarifying of work-related problems), communication at work (communication about limitations and mutual expectations) and problem-solving (developing and implementing solutions). Clark and Stovall (1996) add the concept of advocacy skills that will enhance the cancer survivor's sense of empowerment. It focuses on building skills and coping strategies as a way to prevent or overcome psychosocial limitations. They mention the skills essential in the advocacy skills model as information-seeking skills, communication skills, problem-solving skills and negotiation skills.

Empowerment is important for cancer employees in the sense that it could help them to maintain a positive future outlook and increased quality of life instead of feeling helpless (Clark & Stovall, 1996). According to Swift and Lewin (1987, p. 84) "to be empowered is not only to be 'involved in', but to do."

#### **4.5.4 Other interventions to assist cancer survivors in the workplace**

According to Mellette (1985), cancer represents a wide spectrum of diseases and it is understandable that employers will find it difficult to recognise the prognosis and functional capacity because of the diversity that exists.

Improved guidance and improved information to facilitate the wellbeing of cancer survivors when they RTW would be beneficial to all concerned (Kennedy *et al.*, 2006; Tamminga *et al.*, 2012). Improvement in communication about readiness to RTW and work issues would also help in the RTW process. Tamminga *et al.* (2012) also found that many personal factors were perceived to be facilitators for RTW (such as coping strategies). They suggested a clear RTW plan that includes tasks, hours, responsibilities and the addition of a reintegration counsellor to the cancer care team to provide comprehensive RTW guidance. The RTW process is enhanced for individuals who receive support (practical and emotional) from their employer and colleagues throughout their cancer experience (Johnsson, Fornander, Rutqvist & Olson, 2010; Kennedy *et al.*, 2006; Tamminga *et al.*, 2012). Johnsson *et al.* (2010) found in their study that support from employers and colleagues helped cancer survivors to regain their previous working capacity. Lack

of support meant that cancer survivors had to struggle on their own to regain their previous working capacity.

Nitkin *et al.* (2011) proposed that medical knowledge of the disease and treatment, continuity of care, interventions for cancer-related complaints and interventions to improve relations at work were essential to the management of RTW for cancer survivors. Provision of an educational leaflet to cancer survivors prior to RTW, on what they could expect, showed promising results. A blended learning programme (combination of methods) designed to assist cancer survivors in reintegrating into the workforce could also facilitate the RTW process (Nitkin *et al.*, 2011).

Overall, an interdisciplinary support and rehabilitation plan is necessary to help with the RTW process. This should include assessment of functional abilities to educate the healthcare team and employers about work capacity. It should further include the necessary education related to fatigue management and helping strategies to deal with cognitive limitations, guidance on how to increase capacity for work, recommendations on symptom management and referral to other members of the rehabilitation team (Nitkin *et al.*, 2011).

#### **4.6 MANAGEMENT OF EMPLOYEES WITH CANCER**

RTW is traumatic for the cancer survivor for many reasons, for example a sudden change of pace after months at home, new information and processes to which the individual had to adjust, sensitivity to stress and pressure not experienced previously, loss of confidence due to the physical changes brought about by the cancer treatment, a sense of being avoided by some colleagues who do not know what to say, a sense of being watched and talked about by other colleagues and most importantly, a reminder of life before it was changed so dramatically in every way by cancer (Clarke, 2015). RTW should be a welcome experience of life beginning to normalise again, the opportunity to reconnect with co-workers, who can provide support and a renewed sense of self-worth by being able to contribute and be valued again (Clarke, 2015).

Managers may feel ill equipped to manage employees with cancer, but they have a responsibility to fulfil and it is within their scope to assist employees in dealing

with cancer. Some of the issues managers may have to face include privacy, financial and job insecurity, the rights of employees with cancer, work scheduling, co-worker expectations, morale and communication issues (Roles of managers and tips for employers, n.a., n.d.).

This is a period of change for the cancer survivor as well as the employer who has to manage and facilitate the RTW process. It is thus necessary to discuss the principles of change motivation, as it is important in the transition process.

#### **4.6.1 Principles of change motivation**

The organisation could ease this transition for the cancer survivor back to work by employing the principles of change motivation. Motivational factors and self-efficacy have both been identified in the literature as important in an individual's commitment to perform a specified behaviour. Having confidence to undertake a particular action might be a factor in whether an individual is motivated to change. Once the individual has decided to take action, self-efficacy is important in order to maintain the behaviour and cope with barriers that arise (Dixon, 2008).

Self-efficacy theory (Bandura, 1977) suggests that increasing or rebuilding self-efficacy will boost motivation and performance. The basic idea behind this theory is that motivation and performance are determined by how successful people believe they can be (Bandura, 1982). According to Bandura's social cognitive (learning) theory, an important source of motivation is the many links between goal-setting and self-efficacy. Self-efficacy (Bandura, 1986; a component of Bandura's Social Cognitive Theory) refers to the confidence one has to achieve particular goals in living with or managing problems associated with illness. Self-efficacy is also discussed in Chapters 1 and 3. High self-efficacy is associated with greater effort and persistence to cope with obstacles (Bandura, 1977), as well as enhanced well-being (Lev *et al.*, 2001). Where there is a high degree of self-efficacy in people affected by cancer, there will be improvements in healthcare outcomes, including increased self-care behaviour and decreased physical and psychological symptoms (Egbert & Parrott, 2001; Luszczynska, Sarkar & Knoll, 2007).

The process of change is the central focus of the Transtheoretical Model (TTM) of change motivation developed by Prochaska and DiClemente (1984). The TTM

seeks to include and integrate key constructs from other theories into a comprehensive theory of change that can be applied to a variety of behaviours, populations and settings (Prochaska & DiClemente, 1984; Prochaska, DiClemente, & Norcross, 1992)

Prochaska and DiClemente (1984), in their research on studies of change, found that people move through a series of stages when modifying behaviour. While the time a person can stay in each stage is variable, the tasks required to move to the next stage are not. Certain principles and processes of change work best at each stage to reduce resistance, facilitate progress and prevent relapse. Those include decisional balance (the balance between pros and cons when making decisions as conceptualised by Janis and Mann (1977)), self-efficacy (see Bandura, 1977, 1982, 1986 in previous paragraph) and processes of change (Prochaska & DiClemente, 1984).

TTM classifies people into different stages of change based on their readiness to adopt the change and suggests different interventions based on the individuals' stages. TTM suggests that people progress through five stages when they modify their behaviour (on their own or with help), namely pre-contemplation, contemplation, preparation, action and maintenance (Prochaska, 2000; Prochaska, Prochaska & Levesque, 2001). In the first stage, pre-contemplation, the individual does not intend to make changes. The second stage, contemplation, is when a change is considered and in the third phase, preparation, small changes are made. In the fourth phase, action, the individual actively engages in new behaviour and in the last phase, maintenance, the change is sustained over time. Processes that can produce change in the various phases are as follows: Pre-contemplation phase – consciousness raising, dramatic relief and environmental re-evaluation; contemplation phase – self-re-evaluation; preparation phase – self-liberation and in the action and maintenance phases – contingency management, helping relationships, counter-conditioning and stimulus control (Prochaska, 2000; Prochaska *et al.*, 2001).

Very similar to the TTM model of change is the three-stage model of change, known as the unfreezing-change-refreeze model of Kurt Lewin (Schein, 1995). Edgar Schein (Schein, 1995) provided further detail on this model of change that

will be briefly described here. During the first stage of unfreezing the person becomes motivated to change and has to move past possible anxieties for change to progress. Then in stage two he/she changes what needs to be changed. To some extent this could be compared with the preparation and action stages in the TTM model of change. In stage three the change is made permanent (refreezing). In a comparison with the TTM stages of change, this could be the maintenance stage.

These theories on change also serve as guidance from the literature as considerations in the present research.

#### **4.6.2 Practical assistance for the cancer survivor**

Mitchell and Bruen (2008) offer practical advice for management in assisting cancer survivors. These include the following: allow flexibility in the cancer survivor's work schedule, allow time for breaks in the work schedule, plan work around the person's productive cycle to avoid the fatigue cycle, communicate clearly to the employee regarding expectations, provide feedback on work performance, work with the employee to reach possible solutions, handle co-workers' questions/uncertainties/misconceptions, let the employee join in EAPs to address emotional/psychological/psychosocial issues, focus on what the employee can do (not what he/she cannot do) and investigate the possibility of occasionally letting the employee work from home. In summary, it is important to acknowledge cancer survivors' rights and responsibilities, respect their privacy, show compassion, communicate clearly to all the stakeholders, be flexible in the scheduling of work and create a supportive workplace climate (Mitchell & Bruen, 2008; Varekamp *et al.*, 2009).

In the worst case scenario, some cancer survivors might really not be able to continue working because of the extremely debilitating effects of the cancer and treatment. Nitkin *et al.* (2011) quote Gudbergsson about the danger of the "protection hypothesis" whereby a cancer survivor may be desperate to hold on to a job after diagnosis, which could have undesirable effects over time. In instances where the cancer survivor's work life is questionable, knowledge about legislation would be crucial before any decision is made.

## **4.7 SOUTH AFRICAN LABOUR LEGISLATION**

According to Sieberhagen, Rothmann and Pienaar (2009), employee health and wellness are not explicitly covered by legislation in South Africa. However, the main employment-related legislation that could influence employees' health and wellness by protecting them includes the Constitution of the Republic of South Africa, the Occupational Health and Safety Act, the Labour Relations Act (LRA), the Basic Conditions of Employment Act, the Compensation for Occupational Diseases and Injuries Act, the Unemployment Insurance Act, the Employment Equity Act (EEA) and the Skills Development Act.

The Constitution of the Republic of South Africa, the LRA and the EEA will be discussed, as these are most applicable to the cancer survivor's situation.

### **4.7.1 The Constitution of the Republic of South Africa Act 108 of 1996**

The Constitution of South Africa is the supreme law of South Africa. It provides the legal foundation for the existence of the Republic, sets out the rights and duties of its citizens, and defines the structure of the government.

Section 23 of the constitution states that "Everyone has the right to fair labour practice ..." Therefore, every South African employee has the right to be protected from unfair labour practices (Sieberhagen *et al.*, 2009). In the cancer survivor's case, unfairness might be in the form of discrimination or unfair dismissal. According to Hoffman (2005), an employer cannot treat a cancer survivor differently from other employees as long as the survivor is qualified for the job.

### **4.7.2 Labour Relations Act 66 of 1995**

The LRA aims to promote economic development, social justice, labour peace and democracy in the workplace (Labour Relations Act and Amendments, 2014).

Dupper, Garbers, Landman, Christianson and Basson (2004) mention that the employee is protected against unfair dismissal on the grounds of disability according to the stipulations of the LRA. The LRA, however, provides for the dismissal of an employee based on the employee's incompetence if there is a valid and fair reason for dismissal and a fair procedure has been followed. The dismissal code distin-

gushes between two broad categories of incompetence dismissals, namely poor performance and ill health or injury.

This act will be relevant to the cancer survivor in the instance of dismissal due to incapacity: ill health. However, dismissals for (temporary/permanent) ill health or disability will, according to the South African Labour Guide, only be fair if the employer:

- investigates the degree and duration of the injury or incapacity;
- considers ways of avoiding dismissal, for example getting a temporary worker until the sick worker is better;
- tries to find alternative work for the worker to do;
- tries to adapt the work so that the worker could still do it; and
- gives the worker a chance to be heard before deciding to dismiss him/her.

#### **4.7.3 Employment Equity Act 55 of 1998**

The purpose of the EEA (The SA Labour Guide) is to achieve equity in the workplace, by:

- promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination; and
- implementing affirmative action measures to address the disadvantages in employment experienced by designated groups to ensure their fair representation in all occupational categories and levels in the workforce.

The EEA is applicable to the cancer survivor in reference to unfair discrimination. In considering the cancer survivor's work function, some employers might evaluate the cancer survivor as disabled. What is the meaning of "disability"? According to the EEA it means that people have a long-term or recurring physical or mental limitation and that their prospects of entry into or advancement in employment are limited (Section 1, EEA). The Department of Labour further distinguishes between disability and handicap in that handicap is a constraint or a barrier that puts a person at a disadvantage (Department of Labour, 2013). Dupper *et al.* (2004), debate whether a person with HIV/AIDS can be classified as a person with a disability and at what stage the person will be classified as disabled. They

mention that a person in the asymptomatic phase cannot be classified as disabled. This could also apply to the person with cancer.

It is clear that there are several aspects to consider in the decision-making process of when a person is classified as disabled and when a person is evaluated as not capable of working anymore. Any intervention that aims to facilitate the cancer survivor's RTW should include a measure that assesses the intervention's impact on the employee as well as on work (Nitkin *et al.*, 2011).

#### **4.8 POLICIES AND PROCEDURES AS RESOURCES TO ASSIST THE CANCER SURVIVOR**

According to Dyson (1999), policies provide a broad guide to actions and decision-making. A procedure states what will be done to implement the policy. Procedures are built on policies.

A cancer policy will typically have an introduction stating what the policy is about, who is covered by it and why the company has such a policy. Then the employee diagnosed with cancer might be described in terms of the scope of the policy, what the employee should do on diagnosis, working during treatment, time off during treatment, after treatment, disability caused by cancer, giving up work and unfair treatment. Unlike a policy, which allows the individual some discretion, procedures are more specific in specifying what it is that will be done, by whom and how (Cancer and working guidelines for employers, HR and Line managers, 2006).

Nowrouzi *et al.* (2009), stress the importance of the implementation of a cancer policy that is relevant and available to employees. Although policies are not a solution to problems, they can provide the resources and support available within an organisation and can help to ensure that the individuals affected by illness are managed in a consistent manner (Nowrouzi *et al.*, 2009).

Van Dyk (2005) states that laws and policies are necessary for guidance, but the first guideline should be common sense, ethical and moral values, compassion and basic respect for the human rights and dignity of all people.

## **4.9 ORGANISATIONAL CULTURE TO SUPPORT THE CANCER SURVIVOR IN THE WORKPLACE**

Davies, Nutley and Mannion (2009) mention that organisational culture emerges from things that are shared between people in an organisation. Those include shared beliefs, attitudes, values and norms of behaviour. Thus organisational culture is a way for people to make sense of the organisation by seeing situations and events in similar and distinctive ways (Langfield-Smith, 1995; Morgan, 1986; Williams, Dobson & Walters, 1996). According to Martins and Martins (2009), employees have a perception of the organisational culture based on factors such as support of people, team emphasis and degree of risk tolerance. For the purpose of this study an open organisational culture will be defined as a culture where managers and leaders are approachable and are employee-orientated versus a closed organisational culture where managers and leaders are job-orientated.

Mitchell and Bruen (2008) suggest that organisations should develop a corporate culture that supports continued productivity. In doing so, the employer assists all employees who are managing their health and have productivity issues. In an open system, newcomers are welcomed easily. People are inclusive and take the approach that anyone will fit in well with the organisation. A closed system is more exclusive, where newcomers have to prove themselves. Open cultures have managers and leaders who are approachable, and thus tend to see higher employee satisfaction.

According to the technical assistance guidelines (TAG) (Departement of Labour, 2003) on the employment of people with disabilities issued by die Department of Labour, disability management (DM) should be a workplace prevention and remediation strategy. An organisational culture of early intervention following the onset of a disability reflects an organisation's commitment to continued employment of those experiencing functional work limitations. The TAG also stress the importance of programmes to educate and make employees aware about the role of people with disabilities in the organisation.

Although TAG focusses on disabled people, these same principles are applicable to cancer survivors who might not qualify as disabled as defined by the EEA, but might have limitations, impairments and barriers that might affect their work ability

(Banning, 2011; De Boer *et al.*, 2008; Groeneveld *et al.*, 2012; Hoffman, 2005; Rasmussen & Elverdam, 2008; Tamminga *et al.*, 2012).

#### **4.10 REWARDS AND BENEFITS FOR CANCER SURVIVORS**

According to Coetzee and Schreuder (2010), employee retention refers to initiatives by management to keep employees from leaving the organisation. These initiatives are usually in the form of rewards and benefits (Coetzee & Schreuder, 2010). Rewards are money or another kind of payment for something good that has been done (Merriam-Webster dictionary). Employee benefits are additional things offered to employees over and above salary that increase their wealth or wellbeing at some cost to the employer (Nel *et al.*, 2011).

A reward strategy aims to attract and keep the best employees while ensuring that the organisation's strategic goals are met (Coetzee & Schreuder, 2010; Nel *et al.*, 2011). Nel *et al.* (2011), further state that for rewards to be useful, they must meet the demands and expectations of the employees whose behaviour needs to be influenced. There are two types of benefits. One is called mandatory benefits that employers are compelled to make available to employees and the other is voluntarily benefits (Nel *et al.*, 2011).

Mitchell and Bruen (2008) propose the following as some of the possible benefit strategies that the organisation could apply that will support the cancer survivor: fill economic gaps, revise leave benefits, create transitional work and effect work site accommodation. According to TAG on the employment of people with disabilities (Department of Labour), employees with disabilities should be directed to the DM programme to determine which of the disability benefit options (e.g. sick leave, salary continuance, workers' compensation, etc.) are reasonable and appropriate. The DM programme also coordinates health and behavioural health care, health promotion and EAP. These are all aimed at providing benefits to the cancer survivor.

According to TAG, the employer must ensure that benefit schemes do not unfairly discriminate against any employee with a disability. The employers should investigate and where reasonable, offer benefit schemes that reasonably accommodate employees with impairments, such as vocational rehabilitation and financial compensation.

## **4.11 SUMMARY**

Employees who experience high levels of wellbeing and positive emotions have a greater ability to deal with various stressors at work, have higher levels of job satisfaction, display positive interpersonal relationships in the work context and make greater contributions to organisational effectiveness (Bergh & Theron, 2009). It is therefore important to facilitate the wellbeing of employees with cancer so that they are able to meet the demands of the job and engage positively with others in the work context.

In this chapter I discussed the literature review regarding strategies and interventions aimed at facilitating the wellbeing of the cancer survivor in the workplace. In the following chapter the data, responses and comments of participants are presented, followed by a discussion of these data.

# CHAPTER 5

## FINDINGS

### 5.1 INTRODUCTION

Coming to report on the findings of this study was a long and arduous journey for me. As the data are presented here, the result seems not to reflect the conceptually and psychologically difficult process I went through to come to this chapter. In the previous two chapters, I provide the theoretical background to the study by presenting a literature review on the wellbeing of the cancer employee and a discussion of the strategies to facilitate the wellbeing of an employee with cancer. In this chapter I report on the findings and particularly the themes that emerged from the data in a qualitative reporting style. The findings emerged in constant reflection on the overall objective of the study, which was to explore how cancer survivors experience returning to work in order to develop an understanding of how to facilitate and sustain their wellbeing in the work context.

### 5.2 DISCUSSION OF THE FINDINGS

The findings of this study were obtained through interviews with eight cancer survivors who had returned to work. The data were analysed using the method as proposed by Van Manen (1984), combined with the method provided by Tesch (1990), and the process was explained thoroughly in Chapter 2. First I immersed myself in the transcripts and became intimately familiar with the lived experiences of the cancer survivors when they return to work. My immersion was driven from a phenomenological stance and is reflected on below in a naïve phenomenological reading of the data. After continued careful reflection on the data, I identified meaningful codes and clustered these into themes, writing an interpretation relying on my own intuitive grasp of what was going on in the data (see Terre Blanche *et al.*, 2006).

#### 5.2.1 Naïve reading

The impression I got during the interviews was that most of the participants needed to talk about their cancer experience of diagnosis and treatment and this was confirmed during the naïve reading of the text. This is similar to the findings

of Aldredge-Clanton (1998) who found that cancer survivors tell their stories because it gives them the opportunity to be heard and understood and the fact that it might have value for others gave them hope that there was a purpose in their illness. Thus I found the participants were generally positive, relaxed and spoke spontaneously about their experiences. After initial introduction and orientation, interview conversations flowed with ease and participants engaged with detailed reflection on their experiences, requiring much less probing and initiation on my part than I expected.

During the naïve reading of the transcripts it became clear to me that all of the participants wanted to be positive about the cancer experience and sought normalisation. I also found that there were emotional and physical issues that had an impact on them and the magnitude of these challenges depended on the individual, the cancer and the job characteristics. Throughout the whole reading process it was also confirmed that cancer survivorship represents undeniable phases during which the cancer survivors have to cope with these issues. I also realised that every individual had his/her own way of experiencing and dealing with these issues.

In steering the interviews towards the work situation, I found that most of the participants experienced their employers and co-workers as supportive in the RTW process. It seems that the participants had certain expectations of support they needed from their employers. The nature of the job and the type of support that the participants expected influenced the extent to which cancer survivors coped and adjusted in their RTW process.

In the section below, the themes and sub-themes identified during the thematic analysis are explored and discussed as they are grounded in the data.

### **5.3 THEMATIC ANALYSIS**

From the participants' responses and the resultant processes of data analysis (by myself and an independent coder) it was found that cancer survivors experience various challenges and apply different coping styles when they try to maintain their wellbeing. The following three main themes emerged:

- Physical, psychological and psychosocial **challenges** that influence cancer survivors in their work.
- **Coping strategies** of the cancer survivors to maintain their wellbeing.
- **Employee RTW expectations** in the organisational context.

Each of these themes, with its sub-themes, is presented in this chapter with excerpts in the form of quotations from the participants' interview transcripts to illustrate how the themes emerged and to support the findings. Participants were numbered from P1 to P8 to ensure anonymity in reporting. When quotations are cited from the data, the participant's pseudonym (e.g. P1) is thus used as reference.

### **5.3.1 Physical, psychological and psychosocial challenges that influence cancer survivors in their work**

During the interviews, all the participants talked more about the various challenges that they experienced post-treatment than about anything else. The residua and/or side effects of cancer and the cancer treatment for different types of cancers have different complications for cancer survivors and this has an inevitable impact on their work. The challenges that emerged from the data were physical, psychological and psychosocial in nature.

#### *5.3.1.1 Physical challenges*

The physical symptoms that participants experienced support the findings of Banning (2011), Rasmussen and Elverdam (2008), Shava (2011), Steiner *et al.* (2010) and Taskila *et al.* (2011). The treatment-induced physical impairment of fatigue was a repeating concern for all the participants. Other impairments mentioned by the respective participants were diminished physical capability, hot flushes, pain, hearing loss, headaches and sweatiness.

All the participants mentioned fatigue as disruptive and difficult to manage at work. Participants described their experience of fatigue as something more than just being tired; it was something that caused nausea and that was emotionally draining: *"I get very tired ... get so tired that I become nauseous. Body says sit down otherwise you are going to vomit. At the beginning got so tired. It is much better now. Just after chemo was tough. It is now much better, but still get tired"*

(P2). Participant three relayed how terrible this tiredness was for her: "... *but then after two, three hours, I felt so tired that if I do not get a bed, I will murder for a bed. Terrible thing*" (P3).

Diminished physical strength to perform tasks that they used to do before diagnosis, were a concern for the participants: "*Previously I could manage everything, but no longer. I am not as quick as before because of my mastectomy. My arm does not allow me to do everything*" (P2). Participant one mentioned: "*Now and then it is a little bit detrimental. The patients are sometimes heavy to carry.*" Participant six said that it felt to her as if her strength had been "*cut away*" and that she did "*not have strength to go on. It is horrible.*" Van Weert *et al.* (2005) explain that the physical side effects such as fatigue, reduced muscle strength and diminished physical capacity can be explained by cancer-related and treatment-related factors. This reduced strength, whether physical or psychological, interfered with the participants' functioning.

The hot flushes that participants experienced were a direct side effect of the cancer treatment. Hot flushes are experienced as sudden and temporary episodes of heat and sweating, with possible co-occurring palpitations and anxiety (Carpenter, 2005; Kronenberg, 1994). Pullen (2013) mentions that research has shown that for women with severe hot flushes the ability to work effectively and be productive is seriously affected. Participant six said that it felt as if she was "*constantly on fire*". It was, however, not restricted to women only; a male participant also complained about hot flushes together with the experience of pain: "*Things that get to you in the beginning ... a lot of pain ... scars will be there ... you wonder what is this pain ... and short term memory is a goner. And the hot flushes!*" (P7). The effect of pain could limit a person's activities and make it difficult to work.

Other challenges that participants mentioned were headaches, sweating and the experience of hearing loss (P1 and P5). All of these challenges were aspects that cancer survivors had to deal with and they had to learn to accept and live with some of them for which there was no remedy.

#### 5.3.1.2 Psychological challenges

The psychological symptoms that participants experienced were that some of them were more emotional, experienced impaired cognitive functioning such as

memory loss/forgetfulness, concentration problems, depression and fear of the recurrence of cancer. These findings were supportive of studies conducted among others by Aaronson *et al.* (2014), Adler and Page (2008), Andrykowski *et al.* (2008), Banning (2011) and Steiner *et al.* (2008).

Participants expressed more emotions than before the cancer experience, which seemed to have made them more vulnerable. Participant three was overcome by the difficulty of adapting to the changes that were forced on her by the cancer and the treatment for it: *"I am more emotional than before and also struggling to remember at times. But a person has to adapt to it. It is sometimes difficult. [Tears]. It's a big adjustment and I do not think you ever overcome it"* and participant two mentioned that she experienced strong emotions five years after diagnosis: *"After the operation [cosmetic] it felt like my strength gave way and only then I realised what happened to my body. I was in a dip and for the first time emotional. After five years, for the first time I was emotional"*.

Most of the participants experienced memory loss and being forgetful: *"There are times I am forgetful when I cannot recall"* (P1) and *"I have my blonde moments. I would ask, 'what have I talked about?' And my dad, he is so old, then he has to tell me"* (P3). Other participants complained about concentration problems: *"Concentration is difficult. I must put more into concentration. I put something down here then take another thing. I am not quite focussed"* (P4) and *"I work with money and must be accurate. I cannot concentrate long"* (P3).

Feelings of depression were also mentioned as a challenge. Participant four voiced her emotions and said that she had to take medication to overcome depression: *"I'm very emotional. I have a mild pill because I feel so down, in a deep pit."* Participant seven mentioned that the thoughts of the fragility of his body and the recurrence of cancer made him depressed: *"The fragility of your body ... that's actually sometimes quite depressing as you catch these dips because then you think what's going on inside of me that I do not know about ..."*

Participants mentioned a continuous and debilitating fear of the recurrence of cancer: *"My last check up, three months ago, I had terrible pain under my arms [pointing] and I mean, Hodgkin's lymphoma is lymph cancer you know, and you stress about it ..."* (P7). Participant six, who had cervical cancer, expressed her

fear of another (breast) cancer: *“I must say in my mind it is worse that I am afraid of breast cancer than of any other cancer. Fear that it is somewhere waiting for me ...”* The fear led to constant worry and anxiety about the potential of becoming sick again or of getting another form of cancer, thus the threat of reliving the whole experience once again.

### 5.3.1.3 Psychosocial challenges

The participants also experienced that the expectations of others, image concerns, faith issues and concerns for family members might contribute to psychosocial distress that could interfere with their functioning and wellbeing. These psychosocial concerns that participants expressed were supportive of studies done among others by Aaronson *et al.* (2014), Adler and Page (2008), Messner and Vera (2012), Rasmussen and Elverdam (2008) and Steiner *et al.* (2008).

Participant two mentioned that her family members expected her to continue like before even though, owing to fatigue and diminished physical ability, she could not handle her usual chores: *“My husband! I do not know whether he is in denial, but for him it is always so that I can still do things. He wants me to continue as before”*. Two participants mentioned that their employers also expected them to continue as before. One mentioned that her employer had expectations that she found difficult to meet: *“They [employer] have a lot of expectations and some of the things that they demand ... it is not on your level or your scope of practice, but as long as you are a supervisor, they expect you to have some answers”* (P8). Having to adhere to the expectations of others (even if it is only self-perceived) contributes to the experience of fatigue as participants feel that they need to uphold a front or a façade at work. Another participant mentioned the psychological effort that she had to put in to go on as if nothing was wrong: *“... you’re still bone tired, and you must render a service and it must look as if nothing is wrong. The image you must keep up all the time. It takes more mental energy and strength to keep up the image”* (P6).

Three participants mentioned that they experienced concerns about their body image that influenced their self-image, confidence and behaviour. One participant mentioned being self-conscious about her body image: *“Treat me like any other person. Actually, the stuff that bothers me is when we have to stay over ... If you*

*must undress tonight ... you want to feel that you are with someone that you are comfortable with*" (P5). Another participant felt strongly about not taking medication that would have an effect on her body image: *"I said, I refuse to drink it [anti-hormone tablet], I would rather die. Who wants to look like that for four years?"* (P3). Participant one demonstrated feeling self-conscious about the change in his hair growth that affected his self-image: *"My hair will never be the same after chemo. The growth is bad and there are bald spots [touches his hair self-consciously]"*. These concerns that the participants experienced led to changed social and interpersonal behaviour, for example not wanting to share room space with others (where previously this would not have been a problem), refusal to take medication that could prolong survival status and the wearing of a cap to hide hair. The cancer diagnosis seemed to make people much more self-conscious and less natural in their interpersonal relationships.

Faith issues were also troublesome. Participant seven initially wondered why he was singled out: *"I asked, why me? ... We do not deal with the illness, we deal with the disease and then also have these faith issues ..."*

Together with their own issues and challenges, the cancer survivors mentioned that they were concerned about family members' psychological distress as a result of their illness. Participant five was concerned about her children having retained negative emotions during her battle with cancer: *"I hope that they have not retained negative things. What do you do with unbalanced children?"* and participants three and six expressed concerns about their caregivers, often their husbands, who were intensely affected by the whole cancer process: *"I think sometimes it's hard for my husband"* (P3) and *"... if you have cancer, everyone 'ohs' and 'ahs' about a person with cancer but no one 'ohs' and 'ahs' about the husband and children. That person [the husband] loses you and has to look after the children ... the husband ... has it on both sides"* (P6). In addition to their own anxieties and fears, the participants also carried the burden of worrying about their loved ones' psychological distress as a result of their cancer.

The cancer survivor, the cancer and the characteristics of the job seem to influence how the cancer survivor experiences and handles the above-mentioned challenges. Different participants related different contexts in terms of their

personal support, their work context, the specific job requirements and the stage of cancer in which they were. It is evident that these challenges would have an effect on the confidence, functioning and wellbeing of the cancer employee and the next section deals with themes relating to how cancer survivors cope.

### **5.3.2 Coping strategies of cancer survivors to maintain their wellbeing**

In Lent's model of restorative wellbeing as discussed in Chapter 3, the assumption is made that the process through which people normally maintain their sense of wellbeing may change when they are confronted by problematic external events (e.g. health threats) or internal states (e.g. mood states). The problematic event(s) lead to a coping process that involves appraisal of the threat and the utilisation of coping strategies to protect and optimise one's wellbeing by minimising the threat (Hoffman *et al.*, 2013; Lazarus & Folkman, 1984). Individuals might use more than one strategy of coping as they use reappraisal throughout an event (Folkman & Lazarus, 1980). Positivity broadens a person's thoughts and actions, undoes negative emotions, builds psychological resilience (Fredrickson, 2001) and will affect the appraisal of an event that will eventually determine the coping strategy. It was therefore not surprising to find that participants offered different appraisals of the difficulty of the challenges they faced as a result of having cancer. They also presented with different perspectives in terms of their available resources to cope with these challenges.

Although many definitions and theoretical approaches are used in explaining coping, I found that the coping strategies of the cancer survivors could best be explained within the two primary categories of coping, as suggested by Lazarus and Folkman (1984) namely, emotion-focussed and problem-focussed coping, and I will present the results accordingly. Emotion-focussed coping involves efforts to regulate internal or emotional demands of an event and problem-focussed coping relates to direct efforts to modify the stressor (Lazarus & Folkman, 1984).

#### *5.3.2.1 Emotion-focussed coping*

In dealing with physical challenges, participants mostly used emotion-focussed coping to maintain a sense of well-being. When there had been an appraisal that nothing could be done to change these challenges, participants used a cognitive

reappraisal process in trying to manage emotional distress (as also suggested by Carver, 2011). Thus emotion-focussed coping was directed at regulating the emotional response to these challenges (see Lazarus & Folkman, 1984) and in this research context involved strategies such as avoidance, cognitive reappraisal, distraction tactics, venting of emotions, talking or writing about the experience, communication, seeking emotional support, meaning-making and using humour.

*i. Avoidance coping*

Aldredge-Clanton (1998) found that people distance themselves from an experience to protect themselves emotionally. Some participants demonstrated this by showing denial and detachment in trying to maintain their wellbeing. Participant four was in the two-year period after her cancer diagnosis and she suggested that a person with cancer should take it “day to day”. She demonstrated not being ready to look ahead to the future and was still battling with getting through a day at a time. Related to denial, participant five used the emotion-driven cognitive strategy of downplaying by saying: “*There are worse things than cancer that can happen to you*” (P5). It seems that she had to rationalise the cancer in order to be able to cope with the devastating emotions that went with it. Participant seven who was in his third year after the cancer diagnosis, detached himself from the situation by talking in the third person [“a guy” instead of I] and denied that pain had an effect on his work: “... *more to do with the pains and stuff that a guy has, that’s not pain and things that affect my work at all.*” Aaronson *et al.* (2014) mentioned that post-cancer pain syndrome<sup>3</sup> can have a negative and sustained impact on both physical and psychosocial functioning, thus it is expected that it should have an impact on a person’s work functioning, yet participant seven mentioned that the pain that he experienced did not influence his work. To me, this denial showed that he wanted to believe that the illness did not affect his work and that he was capable of doing his work as before.

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<sup>3</sup> Pain is not only caused by tissue damage produced by the cancer itself but can also be caused by treatment-related toxic or traumatic damage to peripheral and central neural structures, resulting in long-lasting or even late onset neuropathy. Pain may persist after treatment or may emerge several months or even years after treatment has been completed. This is described as post-cancer pain syndrome (Aaronson *et al.*, 2014: p.55).

### *ii. Cognitive reappraisal*

The participants demonstrated using cognitive reappraisal by countering negative emotions. They did this by frequently mentioning positivity as playing a role in their wellbeing. Literature indicates that “thinking positively” is correlated with cancer survivors’ overall level of mental health and mortality rates (Šprah & Šoštarič, 2004). People who have high levels of positive emotionality also seem to perceive, think and act in ways that would lead to positive emotional experiences (Strümpfer, 2006). In this study participants mentioned that to stay positive and focus on the positive helped them in maintaining their wellbeing: “*Depends on oneself to remain motivated ... Am I always going to be emotionally down or will I lift myself out of it*” (P1); “*... but it's what you make of it. If you are positive ... I do not want to be pitied ... Helps not to be down and out*” (P4); “*Positive thinking plays a vital role*” (P5) and “*Yes, I must say psychologically for me it was nice to be back at work and back in the swing of things*” (P7).

One of the participants also mentioned feeling positive about going back to work although she had metastatic cancer: “*It was very nice for me ... So for me going back to work and getting busy, it was nice. It was very nice*” (P8). Participant two did not want to dwell on all the barriers, she wanted to focus on her belief of being indispensable at work: “*That I can honestly say, previously when they wanted something done: [Participant's name] people' and then I am approached. Now even more so. The teacher of the choir is away and it is said there is no one else than me to take over.*” Participant six mentioned that she was needed by her family and this made her resolute to come through this experience: “*I received peace in my soul. My kids and my husband still need me. I am not going anywhere.*”

### *iii. Distraction tactics*

Distraction tactics are activities that people engage in to divert their attention from distressing thoughts or events. Participant eight kept busy to take her mind off emotions: “*It happens when I am alone, that is why I prefer to be busy. But that is when I am alone then all the emotion will come back.*”. Participant four admitted that she wanted to go to work because she wanted to be busy and experience the comfort of being with other people: “*I felt so bad after chemo, but each day I went to work*” and “*I always made sure I was amongst people.*” Although she did

not feel well physically, she still went to work to be among people where she could experience support and focus her thoughts and behaviour on work to take her mind off not feeling well.

#### *iv. Venting of emotions*

For cancer survivors the cancer experience, which entails dealing with the illness, the treatment, their emotions, their family and the environment, is challenging. Cancer survivors experience various emotions on their recovery journey and as mentioned above, they downplay some and overstate other emotions. In venting these emotions they feel better and find a way to discharge some of the bottled-up emotions. In this study I make a distinction between venting of emotions and talking or writing about the experience, in that venting is a more immediate expression of frustration and talking or writing is a more reflective and well-contemplated expression of their experiences.

There were participants who did not experience the support they wished for and they gave vent to their frustration. Participant two experienced family members as non-supportive in the sense that they wanted her to be the same as before: *“My children ... they act as if there is nothing wrong. They think I should still be the same.”* Participant five, who worked in a cancer environment, said that nothing in the way of support was offered; she had to take the initiative if she needed help: *“If I picked up the phone and said, listen I need help, I’ll get it, but nothing is offered.”*

It seemed as if these participants wanted some sympathy and support and did not receive the support they needed and this made them feel dissatisfied and disappointed.

#### *v. Talking or writing about the experience*

All the participants wanted to talk about their cancer experience. It seemed as if when they talked or wrote about it, it helped them to deal with it emotionally. During all the interviews most of the participants talked freely, without much probing, about their cancer experience, how they were diagnosed, the treatment, their emotions and how they got through it. Talking about their concerns by making use of counselling was mentioned as being helpful in maintaining their

wellbeing: “*I went [for counselling], it was needed. It was so nice at oncology where a woman and I could open up and I could discuss everything with her. It did me good*” (P2); “*I must say as far as that was concerned it was a very positive experience [the counselling sessions] ... that buffer to fall back on ... it's quite nice*” (P7).

One participant wrote a poem “Donkernag tot ligdag” (From the dark of night to dawn) expressing her emotions about having cancer: “*The poems ... People ask, ‘When did you start writing?’ I said I am just the instrument. I belong to a writers’ club. I published overseas – locally – nationally – Africa. Christian poetry*” (P6). (Excerpt from the poem):

*Neem ek die treetjies, dag vir dag  
'n Behandeling op 'n slag  
Die pyn ... die naar ... my lewens-aar  
Soms so veel vir my om te dra*

Translated:

*I take small steps, day by day  
One treatment at a time  
The pain ... the nausea ... my life-artery  
Sometimes too much to bear*

The participant coped with her emotions by expressing her emotions in this poem, which she shared with other cancer survivors to convey her expressions of getting through the cancer experience.

#### *vi. Communication*

The participants mentioned that in dealing with some of the physical challenges that caused embarrassment and discomfort, they used open communication to share information with others to explain it and thus also reduced the embarrassment for themselves. Participant five believed that being open and honest about her hot flushes made it easier because then other people would understand: “*I am very straightforward, open and honest. As I get hot flushes, I'll say, ‘excuse me, I am now very hot’ and will then cool myself down.*” Participants two

and four also mentioned that being open in one's communication style helped others to understand the situation: *"But what I would recommend, if something like this happens, you should be open. Unfortunately, some women do not want to talk – especially mastectomy – not all feel confident"* (P2) and *"My child was shocked when she saw me with my bald head – embarrassed at school when I pick her up. But my ex went to school to explain what the situation is and asked teachers to look out for my kid and then all was fine"* (P4). Participant two experienced general understanding from colleagues because she was open about her emotions: *"My colleagues know, they understand because I am open, I tell them how I feel."*

#### *vii. Seeking emotional support*

In addition to its stress-buffering effects, it is shown in this study that social support might help the cancer survivor to work emotionally through this troubling event, as also suggested by Andrykowski *et al.* (2008) and Hoffman *et al.* (2013). Johnsson *et al.* (2010) also mention the importance of social support from the employer and co-workers in the RTW process. Participants mentioned the various kinds of emotional support that they received from their employers and colleagues as valuable in supporting them in handling the challenges.

Participant one mentioned the emotional support shown by his employer by phoning to ask after his welfare: *"There was one doctor who supported me a lot. Very supportive and phoned me to ask how it's going or she sms'ed."* Participant eight said that she received tangible support, which also supported her emotionally: *"They phoned and asked what I needed, I would say fruit or something and they would bring it ..."* Participant four experienced that people at work treated her the same as before (normally) and that they were sensitive to her emotions: *"My colleagues treat me the same. They can see when I'm down. Like yesterday when I went to oncology, they left me alone."* Participant eight expressed her gratitude for the support she received from colleagues: *"Shame, I cannot express it enough. They were all so supportive. All of them during my sick period and after the sick period when I was diagnosed with cancer they were phoning, sending sms's, others were visiting. They were supporting me in different ways."* Participant six mentioned that she was "blessed" in receiving support from a colleague on returning to work: *"I was still blessed. A year before that someone at work also had*

*cancer and because that person came through it, it half opened doors for me at work because as we work close together – you know, for that person it was – fresh in memory, what I must go through. Understanding for me, if I may say so. He had understanding for emotions I had to go through and when I had to get time off to see a specialist and that type of thing ...”* Participant two mentioned the significance of support for her: *“If I need help, there are influxes of people. That is good for me. One of the most important things. A support group is very important.”*

It is evident from the above that positive support assists cancer survivors emotionally, thus helping them in maintaining their wellbeing.

### *viii. Meaning-making*

Meaning-making has a variety of conceptual and operational definitions in the coping literature. It is sometimes portrayed as a separate coping mechanism but in this study I categorised it under emotion-focussed coping, as I found that in dealing with cancer (the stressful impact of the diagnosis, the treatment and living with cancer) the cancer survivor buffered emotions by searching for meaning to cope with loss (for example of health, normal functioning, self-image, self-confidence, etc.). Making meaning of illness involves attempts to integrate one’s understanding of it together with one’s global meaning to reduce the difference between them (Park, 2013). In dealing with the challenges of cancer survivorship, I found that participants used various ways to make meaning of their experience, such as using religion (P4 and P7), having hope and optimism (P1, P5, P7 and P8), striving for normalisation (P8), using the experience to their advantage (P1, P5, P6 and P8), experiencing positive changes (P5), worrying less (P4), experiencing a greater appreciation for things (P7) and making life style changes (P7).

While not all individuals are spiritual, spirituality appears to be central in the meaning systems of many individuals (Park, 2013). The notion that transformation can arise from suffering is an idea common to many religions, including Christianity, Buddhism and Judaism (Aldwin, 2007). Religion helps cancer survivors to cope better. Religion leads to a sense of optimism, control or meaning that affects stress levels and health (Gall & Guirguis-Younger, 2013). Religion was thus found to be something that gave hope and gave the participants something to hold onto: *“I do not want to be pitied. I am thankful that I am well, through*

*the grace of God and wonderful friends ... (P4); "There is no doubt in my ... [tears] ... Really I have no doubt I would have been dead if it were not for the Lord. I mean, I really walked this path with God ... ahm ... many things that were issues, are not issues any more ... and "My faith in the grace of Jesus is the thing that made the difference ... it gave me calmness" (P7).*

Hope and optimism have to do with the future, that things will go well, and motivate people to have a future perspective. Participant eight, who was terminally ill, held on to the hope of completing her studies: *"I told you I am carrying on with my studies ... I am planning to finish ... I chose gastronomical ... I thought I was just going to tell my story, but it does not work that way [laughs]"*. Participants 1 and 5 were optimistic about their future career opportunities: *"My career has not ended" (P1)* and *"I am going to work at GC next year" (P5)*. Participant seven said that he believed he was healed: *"I do not talk about I am in remission, I'm healthy, I'm healed."*

Most of the participants indicated that they strived for normalisation by continuing with work as before. Only one participant was temporarily in another (office) job, while undergoing treatment, to help him cope with fatigue, but afterwards he continued work in his field (regular) position, thus for him a step towards normalisation: *"See I was more on administration. I am now back in my regular position" (P1)*. He said this with a pride as if he was proud of himself being back in his physically demanding job. Participant eight indicated that she wanted to continue as before: *"I want to do everything as before I was diagnosed with cancer. So I just carried on and they got used to me."* Cancer might become an obstacle to normality, specifically to one's sense of control. It seemed as if participants focussed on the things they could control, like work, in an attempt to normalise the situation. Normalisation seemed important to the participants.

Participants used the knowledge and experience accumulated during their cancer experience to their advantage in their work: *"Now easier to work with cancer patients. Can motivate them because I was in the situation itself. Tell them how it's been for me. I have more understanding since I was in the same situation. Easier when fetching cancer patients, easier to talk to them because I have it" (P1); "I tell people when I visit them, those who are diagnosed, you cannot lie to*

*me, I see it in your eyes, I've been there. So yeah that is to my advantage in this work when you walked the road yourself" (P5); "[The] type of work that I do with people affected by trauma or disability or even by death for that matter, I would have more sympathy and passion – much more understanding what that person is going through – more open-minded for cancer and for any severe disease, if I may say so" (P6). Participant eight explained how she used her situation to get results: "For example they say I can't use that machine, I can't do this, then I will tell them, the other team, I end up pushing my top up and showing them my scar, my big scar. So I told them if a person like me can wash a patient, can push a bed around, I think you can also do it? That was the end of the story they just carried on. Much of the time I use it to my advantage."*

Participant five used self-reflection and experienced changes that influenced her in a positive way in her personal life and in her work: *"Emotionally or if you look personality-wise, I am less self-centred than before. Have more compassion with other people. I am ... [pause] ... have more patience than before. I experience pretty things, nice things more intensely than I perhaps would have done previously. I am more grateful, ahm and I am stronger emotionally, especially with what I do now."*

Participant four mentioned that she was less worried about precision and task completion than before: *"A person is always precise in your work ... I was always precise, but now if something is not done, tomorrow is another day."* Participant seven experienced greater appreciation for time spent together with his family: *"But underneath there is a thing in our family, a very much greater appreciation for the time we spend together."* Participant seven also made life style changes to try to restore his health: *"... You have got a second change. I know if I am going to boost my body with the right food, I can definitely recover the damage that is done within me."*

It seemed as if most of the participants were engaged in meaning-making and that the cancer experience changed them in various ways that affected their attitude and outlook on life.

### *ix. Using humour*

The use of humour helped lighten the emotions surrounding the cancer experience. By joking about their prosthesis, participants two and five used self-enhancing humour (Romero & Cruthirds, 2006) which assists them in maintaining self-esteem and control over the threat to their body image: *"I will say, 'oh no wait, this thing is not nice today', then I move the right breast in place. I do this in the presence of the headmaster. He just laughs with me. That's what keeps me up"* (P2); *"I make a lot of jokes about it – in the way that I do not have a breast. Would say "here goes the prosthesis again, I must first fix it"* (P5). Participant eight joked around with others and thus engaged into affiliative humour which lessened her interpersonal tensions and made her feel part of the group (Romero & Cruthirds, 2006): *"So we were sharing our experiences, so we end up laughing at each other."* The joined humour that she shared in the group made her feel that "we are in this together" (Romero & Curthirids, 2006, p. 62). Bennett and Lengacher (2006) reported that humour is a step to recovery and that it heals and gives hope to survive. According to them people also use humour to help others cope, like joking about hair loss or hot flushes to put other at ease.

I found that humour assisted the participants in coping with the emotional aspects of body-image, self-esteem and interpersonal concerns.

#### *5.3.2.2 Problem-focussed coping*

Lazarus and Folkman (1984) explain that problem-focussed coping is directed at managing or altering the problem that causes the distress. In dealing with physical challenges, participants mostly used behavioural modification strategies to cope effectively and maintain a sense of well-being. Participants eventually realise and accept having to change their lifestyle by employing such behavioural tactics in light of the physical challenges being an inevitable consequence of the cancer diagnosis. I have defined these as problem-focussed strategies.

I found that participants focussed on dealing with their symptoms. The problem-focussed coping in this study had more to do with managing emotions, as in many cases the cause of stress (the cancer) could not be removed or the problem (the challenges) could not be solved. In this study it seemed that problem-focussed coping had more to do with the reinterpretation of barriers as challenges and

relieving some of the symptoms. Problem-solving coping is explained regarding the instrumental action (Aldwin & Revenson, 1987) that the participants took in managing challenges and the instrumental support that they received from their employers in assisting them in managing these challenges.

*i. Managing challenges*

In terms of coping, most of the participants with fatigue, for example, integrated even brief periods of rest into their work schedules when possible, or changed their sleeping patterns and some also used extra supplements to combat their fatigue: *“If I rest for 15 minutes, if I just sat down, then it gets better”* (P2); *“I sleep early. In the evenings I am in bed at eight”* (P5) and *“I went on extra supplements, vitamin B injection ... if I am too tired I go home and lie down”* (P5).

It was found that participants wrote things down to be able to recall afterwards and thus help with memory loss/forgetfulness. Participant two used self-talk to calm herself and some also used diaries and calendars to make notes for themselves. *“It frustrates me because I’m used to do things quickly and right. Said to myself: ‘Ah, ah girl remain calm, be calm’ and then I get it done. Must first get calm. But it is so, I forget. Look, like for example in a meeting, I take my diary and I make my notes and put it in ‘file’-diary. I must be able to get back to the information.”*

In dealing with hearing loss, participant five went to test a hearing apparatus for possible future purchasing: *“I went to test a hearing apparatus. Once there is background noise I can’t hear. My hearing is bad. I got the device for testing, but it’s so expensive ... so that is still difficult.”* To help with depression, participant four took medication: *“I’m very emotional. I have a mild pill because I feel so down, in a deep pit.”* Participant five mentioned that she did a programme in mind-body approach and she found that she gained a lot of information and insight from it: *“I have been trained as a counsellor [mind-body approach] and saw how powerful it is ... I saw how bad this unhealthy belief ... was, and they give you the tools to change it.”*

Participants managed the symptoms they experienced of various challenges as best they could and found methods to make life easier for themselves. They further received instrumental support from their employers to assist them in managing challenges.

*ii. Receiving instrumental support*

The participants experienced various forms of support and assistance from employers while they were absent from work on sick leave and when they returned to work to help them in managing challenges. The most general kind of instrumental support participants received from employers was time off when they experienced fatigue or had to go for medical appointments.

A participant mentioned receiving practical support from his employer who gave him ample time off to recover after treatment: *“They have been supportive. I had six months’ time off work”* (P1). Participant eight also mentioned the support she received from her employer in receiving time off and help in the administration of her sick leave: *“They gave me all the time off, even the sick leave forms, they brought to the hospital and when I had to extend my sick leave, they brought it. They brought those forms themselves for me at home.”*

Participants also received support and assistance when they returned to work in the form of their employers being more lenient by accommodating them in various ways. Participant one mentioned that he was accommodated in an office job instead of resuming his regular job where he had to do physical work: *“See, I was more on administration. I am now back in my regular position.”* Participant seven said that he benefited from the company’s wellness programme: *“My employer has a wellness programme and my wife and I each went separately for six sessions to a psychologist.”* Participant three received help from colleagues in the form of them assisting her in carrying heavy things: *“But at work I do not carry heavy stuff, there are people to help.”*

Most of the participants received valuable support from their employers and co-workers on both practical and emotional levels and this clearly enhanced RTW for them. Although the participants perceived the support they received from their employers as valuable, they still felt that certain expectations they had were not met. In the next section these expectations will be discussed, as it could be important in future research regarding facilitating the RTW process for cancer survivors.

### 5.3.3 Employee RTW expectations in the organisational context

As the study focussed on the wellbeing of cancer employees returning to work, the interviews were very much contextualised within the organisational work setting. The significant role of the organisational context in terms of facilitating the whole RTW process was clearly evident as participants narrated their expectations about organisational support, the impact of the particular characteristics of their job and their need to still be regarded as competent in achieving work outcomes of value to the organisation and to themselves.

#### 5.3.3.1 *Expectations and perceptions about organisational support*

In expressing their need for organisational support, participants made suggestions about various things that employers could do to assist them when they returned to work. These expectations could also be categorised into the need for emotion-focussed and the need for problem-focussed support:

##### *i. Need for emotion-focussed support*

The participants had expectations of their employers giving more emotion-focussed support in that they suggested more motivation, opportunities for counselling and for the employer to demonstrate more sympathy with the cancer survivor.

Participant one suggested that employers should motivate employees more: *“They must motivate a person more. If there is no motivation ... feel they are not interested or do not have knowledge about the illness.”* Participant six, who had not received counselling, also felt that employers should provide opportunities for counselling: *“It’s actually something that needs to be considered [counselling]. It is a deep hole into which you suddenly are thrown. And if you do not get out, then what?”* Participant six also mentioned the need for more sympathy from employers: *“If a person needs more time, to have sympathy with that person ...”*

##### *ii. Need for problem-focussed support*

Participants also expected problem-focussed support from their employers in that they suggested instrumental support in granting more sick leave and providing relevant information at the workplace to assist both the employer and the cancer employee in the RTW process. There was also a need for possible interventions to empower cancer employees when they RTW.

Participant one mentioned that employers should have more information about cancer: *“They need to do more research on disease and ask questions. As I always tell people, cancer is not like other chronic diseases.”* Participant two also mentioned information as beneficial: *“Information [literature] ... would be good thing to do, will help people at workplaces”*. It seems as if the participants viewed knowledge about the disease as an important requirement for both employees and employers in the RTW process of cancer survivors. Participant six wanted employers to be more understanding and allow for enough sick leave: *“If a person needs more time, to have sympathy with that person, whether it is unpaid leave or whatever, it will help. Keep open door as needed for that person if he cannot return after those six weeks – that it will be discussed beforehand.”* Participant six expressed the expectation of a company culture that facilitates trust and openness in supporting the cancer survivor on RTW.

Participant five suggested that cancer survivors should be empowered; *“There must be something to prepare them [cancer survivors] for it. It should be part of the treatment. Must work with person so that he is empowered”*. Participant five also had an expectation of organisational policy and culture as an important mechanism to put programmes and interventions in place to assist the cancer survivor on RTW. These programmes and interventions might also include the expectation mentioned earlier in this section about the need for information that could, for example, be provided through in-company training.

It was evident that the participants had different expectations of various emotion-focussed and problem-focussed forms of support they required from their employers in their RTW process. I also found that job characteristics could greatly influence the RTW expectation of cancer survivors.

#### *5.3.3.2 Impact of job characteristics on employee expectations*

Participants mentioned various aspects of their jobs that they found challenging when they returned to work. I found that the participants who had physically demanding jobs (P1 and P2) experienced physical challenges, such as heavy lifting and writing on the board, as more of a challenge than before diagnosis. Their expectations would extend to possible work adaptations such as re-design or additional resources to assist them to do their jobs. This supports the research

done by Spelten *et al.* (2002) and Steiner *et al.* (2008), who found that for physically demanding jobs, cancer survivors may no longer be able to perform tasks to the extent they did before the diagnosis.

The participants who held administrative jobs (P3, P4, P5 and P6) reported the psychological challenge of struggling with concentration as a frustration. The participants in managerial positions had various experiences of the impact of their job demands. Participant seven felt that the work was not an issue because he could delegate. Participant eight experienced work-related stress due to expectations and demands regarding her managerial position that she could not meet: “... they have a lot of expectations and some of the things that they demand it is not on your level of your scope of practice but as long as you are a supervisor they expect you to have some answers.” The participant experienced stress because she could not meet the employer’s expectations, which might indicate that she needed training, coaching or both.

I detected an expectation of a flexible and open organisational culture in both participants on the administration side and the one participant in a managerial position. This might lead to joint responsibility where the participants might feel safe to discuss their limitations and needs and the employer could offer whatever the organisation feels is reasonable to accommodate these employees to do their jobs.

It was clear that the job characteristics had an influence on the cancer survivors’ expectations of support from the organisation to ensure their continued employment.

#### 5.3.3.3 *Expectations regarding work outcomes*

The participants were in different stages of their careers and as such had different views on work outcomes. However, I had the impression that all of them wanted to be still regarded as valuable, competent and part of the team. The predominant expectations that participants had with regard to work outcomes centred on their career prospects, task completion and productivity.

Two participants (P1 and P2) felt that their cancer diagnosis had not affected their organisational career prospects. Participant one felt confident and had an expect-

tation of a future career: "... can always go further in my career. My career has not ended." Participant two used self-promotion in that she described herself as wanted and indispensable: "*The teacher that coaches the choir is away and it is said there is no one else than me to take over.*" Participant two, however, who was five years away from retirement, told me afterwards that her individual career prospects had changed in that she was considering earlier retirement. This contrasting statement, the one of indispensability and the other of considering retirement, demonstrated self-promotion and defensiveness in protecting her self-image (as suggested by Lazarus, 1993). Participant two also demonstrated the need to be in control in that she would be the one to decide when her employment would be terminated. Participant five had the expectation of a promotion in the following year. The furthering of her career met her expectation to be regarded as valuable and competent in the work context. It seemed that the participants had an expectation or a need for recognition, not only from themselves, but also from the employer, to confirm that they were still competent and wanted in the work context.

Participant one mentioned that he still struggled to do some of his physical tasks but that he was in the process of adjusting. This could affect his work outcome in that he had to spend more time on specific tasks. One participant (P4) mentioned that she had a changed view of her work outcomes in that she was not as worried about task completion as before. The expectation of both of these participants (P1 and P4) could be a culture of openness where the participant and the employer could agree on a satisfactory level of performance or make alternative arrangements. Participant three, who worked with finances, mentioned that she could not concentrate for long periods and had to take more rest periods than before. This was likely to have a direct influence on her productivity in that she would take longer to complete a task than before. She was fortunate in that she was employed by her husband (in their own venture) and it was thus easy for her to re-arrange her working hours around her productive time.

There were significant changes in the participants' work outcomes post-diagnosis and I found that they expressed certain expectations regarding their work performance and career prospects. It seemed as if there was an expectation of an

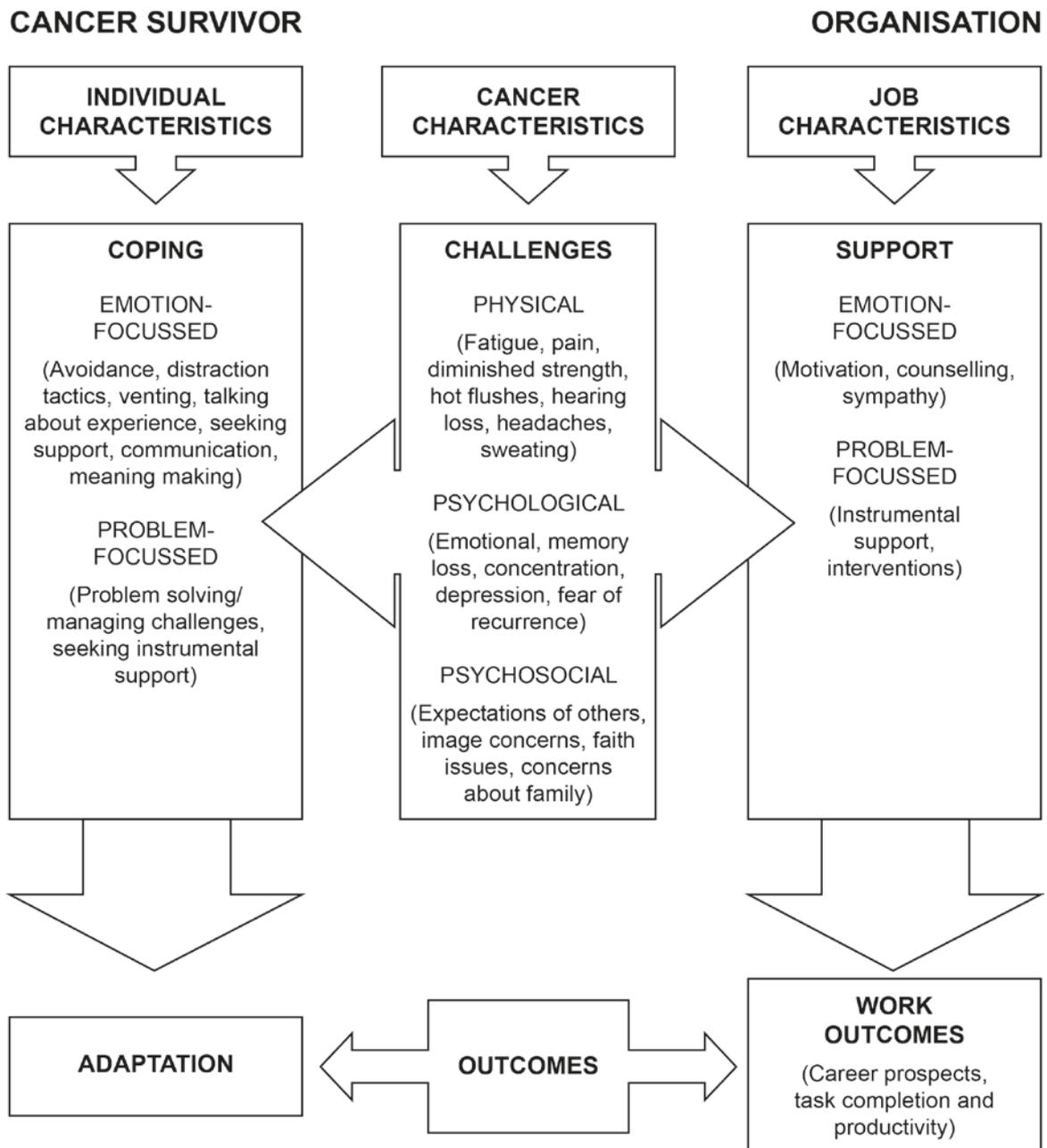
open culture where expected work outcomes could be discussed and where the cancer survivor could receive deserved recognition as a competent team player.

In closing I will present a framework in which I have integrated the themes and sub-themes that emerged in the thematic analysis. This is followed by my reflection on the results that I have discussed thus far.

## **5.4 CONTEXTUAL FRAMEWORK**

Figure 5.1 represents a framework of the themes and sub-themes clustered logically together. The framework depicts the predominant challenges cancer survivors experience when returning to work as central to affecting how they cope on the one hand as individuals, and on the other hand how they cope in the context of the organisation. Predominant challenges include physical challenges (fatigue, pain, diminishing strength, hot flushes, hearing loss, headaches, sweating), psychological challenges (being more emotional, experiencing memory loss, concentration problems, depression and fear of recurrence) and psychosocial challenges (dealing with expectations of other, image concerns, faith issues and concerns about family members). Coping from an individual perspective is understood from the individual's characteristics and is facilitated in different ways, which are mainly categorised as being emotion-focussed and problem-solving-focussed. From the organisational context perspective, organisational support (emotion and problem-solving-focussed) and individual job characteristics will have an influence on the coping efficacy of the individual.

The outcome of successful coping is depicted in the framework from an individual and organisational perspective. From an individual perspective the main outcome relates to the cancer survivor's ability to cope effectively and adapt to his/her altered situation as a cancer survivor. From the organisational perspective the work outcomes relate to retaining and engaging these cancer survivors to enhance work satisfaction and performance.



**Figure 5.1:** Contextual framework

## 5.5 REFLECTIONS

The findings as discussed above reflect many of the challenges that I, as a cancer survivor, also experience in my daily activities. At first, I did not want to talk about my cancer experience at all. That was a taboo subject because I had the perception that I only upset people when I talked about my experience. I started to search for information on breast cancer but soon I was so overwhelmed with the doom and gloom that I stopped altogether. I did not question anything, I just did what I was told. Yet after treatment when I realised, 'Wow, I am through this, and I am still alive', I transferred to a mode of actually wanting to talk about my

experience and share and compare it with others. In reflecting on my experience here, I hope to be transparent about the extent of my involvement in this study. However, in attempting to maintain some objectivity in my stance, I am allowing the theme structure above to guide the manner in which I express my own thoughts and experiences below.

*i. Experiencing challenges*

For me, the physical, psychological and psychosocial challenges I experienced were interlinked, meaning that the one led to the other. I found that I could not remember people's names, or what I had said the previous week. Finding it difficult to find words ('chemo brain') was something I frequently experienced and this was very scary for me. It was as if I had aged 15 years. I also experienced hot flushes and every occurrence thereof was like a miniature panic attack on its own. The warmth grows from deep inside one's belly and pushes up to one's head, rushing through one's veins, causing palpitations, sweating and a face glowing red like a ripe tomato. This still happens to me frequently throughout the day as well as at night, interrupting my sleeping pattern. My hearing and eyes are also affected. It is not so pronounced, but both are definitely affected. These physical challenges cause me to feel less self-confident, more reserved, tired, sometimes depressed and I consequently withdraw from people, thus also leading to a psychosocial challenge.

Although I am not formally employed, I do freelance consultation, which amounts to having meetings, interacting with people and sometimes presenting a workshop. As a result of these physical challenges, especially the hot flushes, I do not want to chair meetings and present workshops anymore, because this is a great embarrassment to me. I also feel that people will not take me seriously if I have to cool myself down all the time, sweating all over the place and then having to read from papers when I cannot remember things.

*ii. Coping and ways to maintain wellbeing*

When I started to comprehend these challenges and what effect they had on me and my quality of life, I searched for solutions to these problems. Unfortunately there is no remedy for some of them (like the hot flushes and memory loss) and I just had to live with them and adjust my approach to work and life. I found ways

to work around the memory loss (making notes, keeping a diary, reminders, etc.) and the hot flushes (taking breaks, making sure I have something to cool me down, scheduling meetings in air-conditioned places, etc.).

Once I had a meeting with three male colleagues in the middle of the summer. It was conducted in an office without any air-conditioning and mid-sentence I experienced a hot flush. I started cooling myself down and the men jumped up and opened some more windows. I just asked them to bear with me for a few minutes, then all would be back to normal and then we could proceed. It was embarrassing and I asked myself how anybody could take me seriously when I had to interrupt important discussions with such a display. Another time I told the children at church a Bible story and it also happened that I had a hot flush. I cooled myself with a little Chinese fan. They observed this and the next time I had story time with them and I experienced a hot flush, they all pulled out their home-made paper fans and started cooling me down! That was so sweet!

I also use distraction tactics such as reading or going for long walks. Both of these strategies help me to relax, decrease anxiety and increase my feelings of self-efficacy.

### *iii. Social support*

Throughout this whole process, I relished the perceived social support that I received. My family was (and still is) always there to give the support I need and I knew that I could always rely on my friends. The community (church) also showed support by asking about my wellbeing and offering assistance when needed. Unfortunately I was let down sometimes by support that I expected and did not receive. An example of this was during treatment when I had to travel to George (every day for a period of five weeks at different times to receive radiation), I had to organise a child minder. People whom I thought would assist me in this were not always available and many times I had to take my six-year-old child with me. He had to sit and wait in the waiting room with some very ill people and must have had terrifying thoughts witnessing some of these people on oxygen, etc.

It was, however, nice to know that there were people who were available, who cared and to whom I could turn when needed. "When I needed it" are the keywords here. It was overwhelming to receive an avalanche of advice from

concerned and well-meaning people. I received advice ranging from eating blackberries or taking vitamins to seeking alternative approaches. I remember a friend visiting me right after my operation, talking loudly and slowly to me as if I had a mental and hearing problem. I could laugh about it all, but it annoyed me and definitely did nothing to help me. Then again, I had a very positive experience of a friend just sitting with me and waiting for me to do the talking or just chatting about something else, taking my mind off things.

#### *iv. Meaning-making*

After some time, I wanted to help others who were experiencing the same challenges. I wanted to share my story and I joined Cansa as a volunteer.

In this period I also reassessed my values and priorities and found that it was my relationship with my family and other people that was important. I also found much comfort in my faith. I had a desire to help other cancer survivors in the RTW process and an item on my 'bucket list' was to complete a master's degree. This was hope and optimism working for me.

In thinking about how I am the same and different to what I have heard from the participants, I have realised that I am in a certain stage of experiencing challenges and coping. This led to further thinking about different phases of adjustment that the cancer survivor experiences after treatment. I also started to realise that I have accepted certain challenges in my life and I have started to use certain strategies in coping with them, as mentioned above. Meaning-making is the primary coping strategy that I now employ in reassessing my life because I experience greater awareness of the finiteness of life. Reflecting upon this, I started to think about different phases in the RTW coping process, as well as different coping styles in various phases. My experience of the distinct and unique ways in which participants cope with RTW, coupled with the conceptual coping model that emerged from the data, confirmed the process nature of coping in this study context and led to further abstraction and meaning-making from the data, to which the next chapter is dedicated.

## **5.6 SUMMARY**

Important concepts and recurring themes were identified in the data. The identified themes were grouped into three main themes (challenges, coping and expectations) and discussed. From the thematic analysis a contextual framework emerged in which the themes and sub-themes are depicted as they are contextually represented in the individual and in the organisation respectively and in relation to coping with the challenges that cancer presents. From a further personal reflection on these initial interpretations and the emerging contextual framework, important trends emerged, calling for further continued iterative reflection, data analysis and theoretical integration, which are explicated in Chapter 6.

Chapter 6, to follow, thus presents a continued hermeneutic reflection and integration of the data with the literature.

# CHAPTER 6

## HERMENEUTIC REFLECTION AND INTEGRATION OF DATA WITH LITERATURE

### 6.1 INTRODUCTION

The initial themes that emerged and were described in Chapter 5 followed a critical hermeneutical reflection against the literature, which formed a constant part of the analysis. My thematic analysis as described in Chapter 5 was integrated from a critical perspective with literature. My continued reflections of how I experienced and identified with the data, as well as reflections shared with my supervisors, led to a critical evolvment of the results, which forms the basis for my discussion in Chapter 6.

### 6.2 INTEGRATION

I used an iterative approach and refined the themes. I followed Thorne, Kirkham and O'Flynn-Magee's (2004) advice and constantly explored and asked questions such as: Why is this here? Why not something else? And what does it mean? In asking these questions and in questioning, 'What is happening here?' I moved from viewing the trees to seeing the forest (Thorne *et al.*, 2004). The hermeneutic circle of understanding was employed, which refers to a circular movement of understanding and interpretation that is viewed as a movement between parts and whole, each giving meaning to the other (Gadamer, 2004). I realised that cancer survivors move through some kind of process or some phases when they return to work. I queried the data and associated interpretations for patterns related specifically to phases of survivorship. In the final stage of analysis, I weaved the thematic pieces together into an integrated whole (Polit & Hungler, 1993).

Through this continued further critical reflection I found that the experiences of cancer survivors formed a phased process and that there was a forward movement from one phase to the next. In reviewing the phases of chronic illness (Fennell, 2012) and the process of recovery from trauma (McGrath, 2001) mentioned in Chapter 3 (paragraph 3.3.3), I found that there were certain similarities in what they described and what I found. The cancer survivors demonstrated

using an avoidance coping style at first, then entered into an emotional stage, whereafter they moved into a problem-solving phase and lastly they tried to make meaning of their cancer experience. I named these phases repression, comprehension, activation and reintegration and illustrate them in Figure 6.1, depicting the similarities with process models from current literature.

<b>RECOVERING FROM TRAUMA PROCESS</b> (McGrath, 2001)	<b>PHASES OF CHRONIC ILLNESS</b> (Fernell, 2012)	<b>PROPOSED PHASES OF COPING</b>
Circuit-breaking	Crisis	Repression
Return of feelings	Stabilisation	Comprehension
Constructive action	Resolution	Activation
Reintegration	Integration	Reintegration

**Figure 6.1:** Similarities in phases of recovering from trauma, chronic illness and proposed phases of coping for the cancer survivor post-treatment

When I reflected further on these phases and themes of adjustment/coping and considered the various expectations that the cancer survivors expressed on their RTW, I found that the support expected from the organisation was also thematic and corresponded to the various phases of coping/adjustment. In reviewing the various theories of change in Chapter 4 (paragraph 4.5), I found that these expectations of organisational support corresponded to an extent to the initial stages of change of the TTM of change motivation (Prochaska & DiClemente, 1984; Prochaska *et al.*, 2001) and to Lewin/Schein's change theory (Schein, 1999). I named these phases of expected organisational support motivation, information, navigation and stabilisation. I illustrate the relationship between the various theoretical models and my proposed phases of expected organisational support in Figure 6.2.

INITIAL TTM STAGES OF CHANGE MOTIVATION (Prochaska 1991; Prochaska, 2000)	LEWIN/SCHIEIN'S CHANGE THEORY (Schein, 1999)	PROPOSED PHASES OF EXPECTED ORGANISATIONAL SUPPORT
Pre-contemplation	Unfreeze	Motivation
Contemplation	Change	Information
Action		Navigation
Maintenance	Re-freeze	Stabilisation

**Figure 6.2:** Relationship between the various theoretical change models and the proposed phases of expected organisational support

I then integrated all of these phases and relevant themes into the phases and themes of individual adjustment/coping and expectations of organisational support in relation to challenges cancer survivors experience post-treatment (see Figure 6.3).

INDIVIDUAL		ORGANISATION	
PHASE	COPING	PHASE	SUPPORT
<b>Repression</b>	Avoidance, distraction tactics, venting	<b>Motivation</b>	Encouragement, counselling, sympathy, tangible support
<b>Comprehension</b>	Cognitive reappraisal, talking/writing, social support, humour	<b>Information</b>	Cancer Information
<b>Activation</b>	Communication, managing challenges	<b>Navigation</b>	Instrumental support
<b>Reintegration</b>	Meaning-Making	<b>Stabilisation</b>	Programmes and interventions

**Figure 6.3:** Phases and themes of individual adjustment/coping and expectations of organisational support in relation to challenges cancer survivors experience post-treatment

In the coping phase named repression, the cancer survivor expressed a need for motivational organisational support. The second phase, comprehension, led to a need for information to add to employers' knowledge about cancer to facilitate support, whereas in phase three, activation, the cancer survivor expected navigation and in the last phase, reintegration, the cancer survivor expressed an expectation of stabilisation. These various phases of individual coping and expected organisational support are next discussed in more detail.

## 6.3 PHASES IN INDIVIDUAL COPING AND EXPECTED ORGANISATIONAL SUPPORT

I found that the cancer survivors moved between the phases of repression, comprehension, activation and reintegration post-treatment when they tried to normalise their lives. Throughout these phases they also expressed certain expectations regarding organisational support, namely motivation, information, navigation and stabilisation. Some of the challenges that the cancer survivors experienced remained unsolved and only the cancer survivors' perception and way of coping with them changed. During the interviews it was evident that cancer survivors expressed certain expectations regarding support from the organisation and that this also changed according to the phases of adjustment. A short description of the major themes within the four phases is provided. Quotations are again accompanied by pseudonyms (P1, P2, etc.).

### 6.3.1 Phase one

A phase is described as a "stage of change or development" (The Concise Oxford Dictionary). In phase one the cancer survivor uses certain defences to repress realities in order to protect the self emotionally and express an expectation of motivational support from the organisation.

#### 6.3.1.1 *Individual coping: Repression*

Repression and suppression are differentiated in literature. Suppression is defined as "a defence mechanism in which a person intentionally avoids thinking about disturbing problems, desires, feelings or experiences" (DSM IV, 1994, pp. 756–777) and although researchers have differing definitions of suppression, all agree that it is a conscious process. Freud used the terms suppression (a conscious process) and repression (an unconscious process) interchangeably throughout his career (Erdelyi, 1990; Erdelyi & Goldberg, 1979). I use the term repression, as it is described in the online Psychology Dictionary as a form of denial or other form of mental defence whereby unpleasant or hurtful realities are repressed and negated in order to protect oneself emotionally.

In this **repression** phase the cancer survivor is still struggling with the aftermath of the treatment and side effects, while also living under the threat of premature

mortality. Repression was demonstrated through the use of avoidance coping, distraction tactics and venting, as discussed in Chapter 5. These are all part of emotion-focussed coping. These avoidance mechanisms were applied to protect the self against the uncontrollable (Roth & Cohen, 1986).

Participants who were in the one to three-year post-treatment period were still trying to comprehend their situation and were most likely to have a 'take it day by day' approach. In particular these participants demonstrated a repressive orientation, which they demonstrated with defences such as denial and detachment. P7, for example, expressed both denial and detachment in stating: *"It's actually my psychological stuff. It is not work-related ... more to do with the pains and stuff that a guy has. That's not pain and things that affect my work at all."* He talked in the third person about his pain (*"pains and stuff that a guy has"*) as if to detach himself from the situation. He also showed signs of denial, mentioning that the pain and 'things' did not affect his work at all.

Cancer survivors expressed feelings of depression, loneliness and emotional turmoil in the initial stages of returning to work. The fear and anxiety of recurrence brought about low moods, as is evident from the words of various participants: *"For you catch these dips, because then you think, what's going on inside me that I do not know about ..."* (P7); *"I take it day to day"* (P4) and *"I'm very emotional. I have a mild pill because I feel so down ... in a deep pit"* (P4). Participant eight also expressed feelings of loneliness when I asked her how it was to be back at work after treatment. She explained that it was nice to be back at work because she *"felt so lonely because everyone else in the house they wake up in the morning and they go to their respective places and I am sitting ..."* She also explained that she was more emotional than before: *"That is something new happening to me, if something happens to someone else, I also cry. I was not usually like that."*

The cancer survivors used distraction tactics to divert their attention from distressing thoughts. They did this by keeping busy: *"It happens when I am alone, that is why I prefer to be busy. But that is when I am alone then all the emotion will come back"* (P8) and by being among other people: *"I felt so bad after chemo, but each day I went to work" and "I always made sure I was among people"* (P4).

Venting was used in the initial phase of repression to discharge some of the emotions the cancer survivors experienced. This was also a form of distraction, as they diverted their thoughts from the real and concentrated on trivial issues. The venting of emotions concentrated on non-support issues: *"My children ... they act as if there is nothing wrong. They think I should still be the same"* (P2) and *"If I picked up the phone and said, listen I need help, I'll get it, but nothing is offered"* (P5). It seems as if these participants wanted some sympathy and support and did not receive the perceived support they needed. This made them feel dissatisfied and disappointed.

#### 6.3.1.2 *Expected organisational support: Motivation*

In this phase the expectations regarding organisational support focussed on the **motivational** need of the cancer survivor. Motivation is defined by Robbins *et al.* (2009) as "processes that account for an individual's intensity, direction and persistence of effort toward attaining a goal" (p. 144). The expectations the participants expressed of encouragement, counselling, sympathy and tangible support, in the form of more time off, was an effort to regain direction and self-confidence at work.

One participant who was diagnosed less than three years before mentioned the expectation of encouragement: *"They [the employer] must motivate a person more. If there is no motivation, it feels as if they are not interested or do not have knowledge about the illness. They need to do more research and ask questions"* (P1). This particular participant had a need for the employer to have more information, to show interest and to encourage. It seems as if this participant needed re-assurance and more leadership behaviour.

Participant six said that counselling was needed to assist cancer survivors in the handling of emotions: *"It [counselling] is actually something that needs to be considered. It is a deep hole into which you are suddenly thrown. And if you do not get out, then what?"* The expectation was also that sympathy in the form of tangible support should be given, for example extended leave to give the cancer survivor the chance to recover and be prepared to return to work: *"If a person needs more time, to have sympathy with that person whether it is unpaid leave or whatever ..."* (P6).

As shown in the coping strategies that the cancer survivors used in this phase, they repressed their emotions, which might initially help them in coping, but in the long run might be not particularly effective (Lazarus, 1993). They therefore needed assistance with dealing with realities. An organisational culture of trust and openness would be beneficial in this phase. The employer can effect this by, for example, letting the employees dictate what they can or cannot do, letting them feel valued, keeping them occupied, showing empathy, considering flexitime or working from home, revising leave benefits, creating transitional work, looking at work site accommodation and using EAPs.

### 6.3.2 Phase two

In phase two the cancer survivors experienced that there were changes and that they could not be the same as before they got cancer. During this realisation the cancer survivors worked through their emotions by telling their stories and they expressed a need for information to enable the employer and co-workers to understand and to have knowledge about their illness in order to support them in returning to work.

#### 6.3.2.1 Individual coping: Comprehension

The second phase for the cancer survivor is that of **comprehension**. They now have the need to tell their story in detail. The participants want to talk about their cancer experience. It is as if they need to talk themselves back into normalcy.

Participant six wrote a poem about her cancer experience and called it “Dark of night to dawn” (“Donkernag tot ligdag”). The following is an extract from the poem:

*“tog eendag – soos ’n ewigheid verby  
Kom die boodskap – ek is bevry  
Is daar ’n blydschap meer volmaak  
Om weer die lewe te kan smaak*

*My hart is te klein, die gevoel te groot  
Daar is nou lewe waar eens dood  
Besef dat elke sekonde geleende tyd  
’n Wonderwerk is vir jou en my”*

Translated:

*“yet one day like an eternity passed  
Came the message – I was freed  
Is there a more perfect joy  
To once again taste life*

*My heart is too small, the feeling too large  
There is now life where once was death  
Realise that every second of borrowed time  
Is a miracle for you and me”*

The participants in the three years and longer post-treatment period gave much more detail than those in the three years and less post-treatment period. The participants who seemed more reserved also gave less detail than those who liked to express themselves. Some participants seemed to be obsessed by health issues and wanted to discuss these in detail.

They used cognitive reappraisal, talking or writing about the experience, support and humour as methods to cope in this phase. The participants used cognitive reappraisal by re-evaluating the situation in a more neutral or positive way. In doing this, they tried to establish positive emotions. In this phase, the support of family, friends and colleagues was of the utmost importance in order to serve as a sounding board and feedback mechanism in managing these emotions. The participants described social support as valuable in the comprehension phase: *“If I need help, there are influxes of people. That is good for me. One of the most important things. A support group is very important”* (P2). Thornton and Perez (2007, p. 192) mention that relationships and interpersonal processes are important because the cancer survivors' social environment plays a crucial role in their psychological adjustment to cancer.

Participants used humour in the comprehension phase to gain control and decrease tension. They used self-enhancing humour to assist them in maintaining self-esteem and control over the threat to their body image and affiliative humour, which decreased interpersonal tensions and made them feel part of the group (Romero & Cruthirds, 2006). I found that humour assisted the participants in

coping with the emotional aspects of body-image, self-esteem and interpersonal concerns.

#### 6.3.2.2 *Expected organisational support: Information*

Communication is always an important part in any organisational process. It is a release for emotional expression and aids in the fulfilment of various needs (Robbins *et al.*, 2009). The participants already had reasonable knowledge about their illness and the prognosis but they needed their employers and co-workers to share in this knowledge by gaining relevant **information** in this phase to facilitate decision-making. The participants mentioned that the employer needed more information about cancer: *“They need to do more research on the disease and ask questions. As I always tell people, cancer is not like other chronic diseases”* (P1). Participant two also mentioned information as beneficial to employees and employers: *“Information [literature] ... would be a good thing, will help people at workplaces.”*

It seems as if the participants viewed knowledge about the disease as an important requirement for both employers and co-workers in the RTW process.

### 6.3.3 Phase three

In phase three the cancer survivors took action. They managed some of the challenges and in doing so demonstrated the use of positive psychology constructs. They wanted to move forward and to do this they needed guidance or navigation from the employer in the form of instrumental support.

#### 6.3.3.1 *Individual coping: Activation*

After comprehension, there was a need for **activation**. This is a problem-solving phase but still with much emphasis on emotions. The cancer survivors took action by communicating, using support and managing challenges. As part of comprehension, the need for understanding was underlined. The second and third phases (comprehension and activation) go hand in hand. To go forward, the cancer survivors felt they had to act. Acting and feeling became an engine that propelled them forward (McGrath, 2001).

In trying to explain their illness and secure understanding and assistance, the participants had to be willing to communicate. They had to take this step in order to gain understanding. Most of the participants mentioned that being open and honest in communicating the challenges they experienced improved their chances of acceptance and understanding. Some people may find it difficult to communicate some of the challenges that they experience because of fear of victimisation, stigmatisation or feeling ashamed. Participant one mentioned that *“not everyone, just those on my shift know”* that he had cancer, demonstrating that it was an embarrassment and he did not feel comfortable to let everyone at work know about his illness. Another participant, who worked in an office with other women, said that she could not imagine what it would be like to work in a mixed group (genderwise) and talk about the challenges one experienced as a cancer survivor: *“Many of my colleagues understand because we work with cancer people. I do not know if in other jobs you will have such understanding. Such as police [for example], might not ... We are just women ... I do not know how it would have been if we had a man that worked here”* (P5).

The participants had ways of managing some of the symptoms. By dealing with these challenges that they faced, they demonstrated the positive psychology constructs of SOC, self-efficacy and LR:

*“I get very tired. I get so tired that I become nauseous. My body says sit down otherwise you are going to vomit ... If I rest 15 minutes then it gets better, if I just sit ...”* (P2) and *“Writing on the blackboard is hard, but I made a bench for myself to stand on to make it easier”* (P2).

*“To remember, I write everything down. If I don’t, I will forget”* (P5); *“I am very straightforward, open and honest. As I get hot flushes, I’ll say: ‘Excuse me, I am now very hot’ and then cool myself down”* (P5).

Participant one demonstrated the positive psychology construct of LOC by stating that he had control over his emotional state: *“It depends on myself to stay motivated. Am I always going to be emotionally down or will I lift myself out of it?”*

I found that there was a narrow margin between the two constructs of potency and hardiness. Participants 4 and 8 demonstrated these two constructs: *“I felt so*

*bad after chemo, but each day I went to work*” (P4). “You see when I came back [to work] people said: ‘You are not supposed to wash patients’, ‘You are not supposed to do this’, ‘You are not supposed to do that.’ I said: ‘I am going to do that’” (P8).

By using the positive psychology constructs of optimism and hope, participants 4 and 8 showed optimism by making plans for the future and participant seven showed hope by believing that he was healed: “*I’m going to work at GC next year ...*” (P4); “*I’m carrying on with my studies*” (P8); “*I do not talk about I am in remission ... I am healthy, I am healed*” (P7).

The participants demonstrated an amount of resilience in that they moved through the phases and did not get stuck in repression for a long period: “*I’m going to make the best of it*” and “*I will not lie down*” (P1); “*I want to do everything as before I was diagnosed with cancer*” (P8).

I found that the participants who demonstrated these positive psychology constructs had an active coping approach to adjusting to their situation.

#### 6.3.3.2 *Expected organisational support: Navigation*

**Navigation** is described as putting cancer survivors in a favourable position so that they can take the necessary action to adjust. This was done by means of giving instrumental support. The most general kind of instrumental support participants received from employers was time off when they experienced fatigue or had to go for medical appointments. Participants also received support and assistance when they returned to work in the form of their employers being more lenient by accommodating them in various ways, such as transitional work and EAPs. Co-workers also assisted in giving tangible support by helping with physically demanding jobs. All of these assisted the cancer survivors to cope actively and experience a more successful RTW. Another form of instrumental support could be redesign of work to assist cancer employees who experience physical challenges in completing certain tasks. An example of this is participant two, who had trouble with her arm and found writing on the board troublesome. The employer could look into alternatives to assist her, such as providing an interactive whiteboard. Hryniuk and Waechter (2011) suggest that a comprehensive cancer

assistance programme will enable employers to navigate employees through the process to ensure a timely and healthy return to work and productivity.

#### **6.3.4 Phase four**

In phase four the cancer survivors find ways to integrate part of themselves before the illness with the person they have become (Fennell, 2012) and they need support from the employer in the form of interventions in finding stabilisation.

##### *6.3.4.1 Individual coping: Reintegration*

In the **reintegration** phase the cancer survivors incorporate meaning into their cancer experience by using various methods such as reassessing values and priorities. This is a learning, growth and meaning-making phase. The positive psychology constructs of meaning-making, hope and optimism are reflected in this phase.

The participants made meaning out of their experience in various ways. They showed acceptance and applied their experience by using it to their advantage:

*“They say, I can’t use that machine, I can’t do this, I can’t do that. I end up pushing my top up and showing them my scar, my big scar. So I told them if a person like me can wash a patient, can push a bed around, I think you can also do it? That was the end of the story, they just carried on. Much of the time I use it to my advantage” (P8).*

*“Look what I can say now, it is easier if I go to patients. It is easier to work with cancer patients. I can motivate them because I was in the situation myself. I can tell them how it’s been for me. I have more understanding” (P1).*

Some participants experienced positive change in themselves and an appreciation of life in general:

*“Emotionally or if you look personality-wise, I am less self-centred than before. I have more compassion with other people. I have more patience than before. I experience pretty things, nice things, more intensely than I perhaps would have done previously. I am more grateful, ahm ... and I am stronger emotionally, especially with what I do” (P5).*

The cancer survivors expressed a change that had occurred in them in that they had developed a different view of life. They reassessed values and priorities by spending more time with family, made lifestyle changes and were aware of attitude changes.

*“But underneath there is a thing in our family, a very much greater understanding for the time that we spend together” ... “...you know it is borrowed time we spent with each other. So (sigh) ... you know ...” (P7)*

*“I know if I am going to boost my body with the right food I can definitely recover the damage that is done within me. I can recover because that’s how our bodies work. I have to give it enough fuel. ... Do you enjoy everything as always and you overeat on steaks and ice cream and such or do you say no, I’ve got a second chance and use it right” (P7).*

*“A person is always precise in your work. I was always precise, but now, if something is not done ... tomorrow is another day. I am not so worried about everything” (P4).*

#### *6.3.4.2 Expected organisational support: Stabilisation*

In the reintegration phase I detected a need for **stabilisation**. The cancer survivors had come to terms with their changed circumstances and accepted that they needed support in the form of training or coaching to help in the stabilisation process. Participant one mentioned the need for ‘motivation’, which could include coaching or some other intervention and participant five expressed the need for an intervention to give cancer survivors personal control: *“Walking the cancer road there must be something to prepare them for it. It should be part of the treatment. They must work with him so that he is empowered.”* The need expressed here, is for the development of self-efficacy and the growing of a person’s self-confidence.

Interventions that focus on the wellbeing of employees need to develop and enhance wellbeing constructs within the person as well as creating a receptive interpersonal, group and organisational environment (Bergh & Theron, 2009).

## **6.4 SUMMARY**

In this chapter the thematic pieces, literature and theory were weaved together to illustrate the experiences of cancer survivors when they return to work. Critical reflection led to the phases and themes of adjustment/coping and expected organisational support in relation to challenges the cancer survivors experience post-treatment. In these phases the individual and organisational perspectives are reflected by means of individual coping and expected organisational support. In the following chapter the conclusion and recommendations will be discussed.

# CHAPTER 7

## CONCLUSIONS AND RECOMMENDATIONS

### 7.1 INTRODUCTION

In conclusion to the study, Chapter 7 presents a summative overview of the research and findings in relation to the initial research objectives I set out to achieve. In this chapter, conclusions are drawn on the basis of the findings presented and discussed in Chapters 5 and 6, as well as regarding the objectives of the study. The limitations of the study are critically considered and recommendations are made in terms of understanding and management of cancer survivors when they return to work. A theoretical contribution is made by means of the process model indicating the maintenance of wellbeing of the cancer survivor on RTW and the explanation of the phases and themes of adjustment/coping and expected organisational support in relation to challenges cancer survivors experience post-treatment, which could be beneficial in facilitating the survivors' wellbeing. Recommendations for possible future research will also be discussed.

### 7.2 SUMMATIVE REFLECTION ON THE FINDINGS

The overall objective of the study was to explore how cancer survivors experience returning to work in order to develop an understanding of how to facilitate and sustain their wellbeing in the work context. From this overall objective, I formulated several specific research questions in Chapter 1. As the results of the study are presented in Chapters 5 and 6, the main findings regarding the research questions are discussed below.

#### 7.2.1 Challenges cancer survivors face in the working environment

Although many of the participants seemed to adjust well, they did experience unique challenges when returning to work after treatment. The challenges that the cancer survivors reported were clustered into three categories, namely physical, cognitive and psychosocial challenges. These challenges made it difficult to function as before the diagnosis. Physical challenges such as body impairment, hot flushes, pain, hearing loss, excessive sweating and fatigue were common among all the participants. In terms of cognitive challenges, cancer survivors experienced

memory loss and concentration problems, which they had to deal with while trying to be as productive as before. Psychosocial challenges included depression, being more emotional, living up to the expectations of others, experiencing body image concerns, faith issues and concerns about family members' handling of the cancer diagnosis.

The extent to which the cancer survivors experienced the various challenges was interdependent on the characteristics of the cancer, the cancer survivor and the job.

### **7.2.2 Cancer employees' perceptions of challenges faced when returning to work**

It was found that the participants had different perceptions about the challenges they faced when they returned to work. Some of the participants denied these challenges and continued as before. Most of the participants wanted to talk/write about their experience and some got emotional in sharing their experience. Most of the participants wanted to deal with the challenges and used various coping styles in doing so. Some participants experienced the challenges as a learning experience and used them to their advantage in the workplace. These differences found in cancer survivors' perceptions led to further critical reflection and integration with literature, eventually leading me to an RTW process model. The basic assumption of the model explains that although many of the identified challenges will remain, it is the perception of these challenges, the way of coping with them and the employees' expectations in the work context that change throughout the phases of the RTW process.

I found that in the various periods post-treatment the cancer survivors' responses were different. Specifically cancer survivors in the period three years and less post-treatment expressed detachment, denial, depression and faith issues. The survivors in the period three years and more post-treatment were in various phases of comprehension, activation and reintegration. In these different phases, survivors presented with different methods of coping with RTW.

### **7.2.3 Methods cancer survivors used in maintaining their wellbeing when returning to work**

It was concluded that cancer employees applied various methods to maintain their wellbeing when they returned to work. The cancer survivors appraised their situation and then used certain coping strategies to protect and optimise their wellbeing. In this regard the data in terms of coping methods were critically reflected upon against Lent's model of restorative wellbeing (Hoffman *et al.*, 2013).

The methods the cancer survivors used in trying to maintain their wellbeing on RTW are expressed in the phases of repression (where they just continue as before, denying challenges), comprehension (where they need to express emotions and come to terms with the challenges), activation (dealing with symptoms, using resources) and finally reintegration (making meaning of the whole experience). It was found that the participants in managerial positions experienced fewer challenges regarding work than for example the participant who had to do physical labour (fetch, carry, etc.). I found that the period post-treatment had an influence on the cancer survivors' responses.

The importance of positivity was mentioned throughout this study and it corroborates Fredrickson's broaden-and-build theory (Fredrickson, 2001), which states that positive emotions broaden a person's thoughts and actions, helping to build personal resources.

### **7.2.4 Accommodation and management of challenges to the benefit of both the organisation and the employee**

It is important to acknowledge that cancer survivors have different needs and that they are in various phases of reintegrating themselves in the work situation. They adopt various coping styles and express expectations of organisational support in their RTW process that correspond to the respective coping phases. It will be beneficial to both the cancer survivor and the organisation if there could be effective facilitation in the RTW process by understanding and responding appropriately to the different coping styles and consequent work-related expectations. The cancer survivors' expectations were related to a need for motivation (encouragement, counselling, sympathy and tangible support), information (information to aid the employer in understanding and coping), navigation (instrumental

support) and stabilisation (interventions). These expectations were used as a basis for further elaboration of the RTW process model by identifying concurrent phases of organisational support and intervention. As there is a need for the organisation to fulfil these expectations through the identified phases, it became clear that the development of self-efficacy throughout these phases is an important objective of successful coping in the RTW process.

### **7.3 STRENGTHS OF THE STUDY**

I am also a cancer survivor, which made it easier for me to build rapport with the participants, enabling them to share their experiences more easily and openly. The fact that I am also a cancer survivor may have increased bias, yet in the unique context of this study I believe that it enhanced the researcher's empathy and understanding. As suggested by Lavery (2003), my biases and assumptions were embedded in and essential to the interpretive process. Babbie and Mouton (2010) also acknowledge the value of understanding the research context from an insider perspective, thus enhancing the authenticity of the findings. I kept an open mind and from the start kept reminding myself that all people are different and experience illness differently. I, however, also used this bias by interacting with the cancer employees in sharing and interpreting this complex lived experience called survivorship. In particular I engaged in personal reflections during and after data analysis to enable myself to keep perspective as to how my experiences were unique, similar and different to those of the participants.

Although only eight participants shared their lived experiences with me, they were from different socio-economic backgrounds and had different primary cancer sites and this provided information that was likely to be transferable to other cancer employees. The participant sample was also diverse in terms of their different work contexts and I believe the great variation in the sample (Patton, 1990, p.172) in fact facilitated the identification of various phases in the RTW coping/adjustment process and thus enhanced the transferability of the emergent RTW process model.

## **7.4 LIMITATIONS OF THE STUDY**

Owing to the qualitative nature of the study, my judgement regarding data gathering and data analysis was very important. I was the primary instrument in the gathering and analysis of the data. To minimise the possibility of researcher bias, I used reflexivity throughout the process. I also used an external person to do the data analysis to verify my findings. Most of all the findings were consistently discussed and reflected on in depth with my two supervisors, which enhanced the richness and rigour thereof.

Seven of the participants were Afrikaans-speaking. Only one participant was English-speaking. My home language is Afrikaans, therefore no language difference was present in data gathering, transcription and during the first analyses. I made sure that the translation did not interfere with the intended meaning. I did this by using back translation (as mentioned in Chapter 2, paragraph 2.5.4.1) and verification by an external data analyst.

Given the small number of participants, there might also be the possibility that the participants were employed by organisations that were more positive about RTW procedures and thus the comments about support from the employer must be seen in that light. Two of the participants were employed by close family members (husband and ex-husband) and this also reflected a more positive outcome for the cancer survivors. The study was performed in one region and the participants were sourced in only one oncology and cancer support institution.

I acknowledge the limited generalisability of the findings in view of it being a narrative exploratory study with limited participation.

## **7.5 RECOMMENDATIONS**

The model of phases and themes of individual adjustment/coping and expectations of organisational support in relation to challenges the cancer survivors experienced post-treatment (Figure 6.3) can be used to develop an organisational policy or framework for the development of a reintegration counselling programme to assist the cancer survivor in the RTW process. In order to apply the needs and support required in each phase, I recommend the following:

- The RTW process should be facilitated by a clear RTW plan that includes tasks, working hours and responsibilities.
- A reintegration counsellor (e.g. an industrial psychologist) should be added to the cancer care team to provide comprehensive RTW guidance.
- Counselling must be an integrated part of the RTW process and measures should be taken to ensure that every cancer survivor has access to and receives counselling services. Counselling before RTW should be compulsory.
- There is a need to improve the lines of communication in the workplace
- With regard to the needs of cancer employees and the support available to them, specifically in facilitating the coping process. Cancer employees have a responsibility to communicate their needs and willingness to work towards a successful RTW process.
- Cancer survivors must take responsibility for self-management. This could be facilitated by helping them in the empowerment process.
- Overall, an interdisciplinary support and rehabilitation plan is necessary to help with the RTW process. This should include assessment of the cancer survivors' coping efficacy and support in facilitating productive re-entry into the workplace.
- It is necessary for employers to make sure that they adhere to the relevant legislation concerning the accommodation and management of cancer employees and to integrate this in relevant policies.
- Organisations should develop a culture that supports employees who experience health predicaments and use the proposed phase model in giving the necessary support.

Recommendations for further research:

- Given the diverse role of human resources, further research is required to understand the role that they play in the cancer survivor's RTW process.

- A longitudinal study on the impact of rehabilitation and interventions aimed at facilitating the wellbeing of the cancer survivor when he/she returns to work would be helpful in the decision-making process.
- Further research is necessary on the effect of work requirements, the atmosphere at work and personality on the RTW process.
- Quantitative research on illness perception and other positive psychology constructs could be beneficial to add to the available knowledge about the cancer survivor.
- This study could also be the conceptual basis for the development of an intervention programme that could be evaluated in future research.

## 7.6 CONCLUDING REFLECTIONS OF THE RESEARCHER

*If I could paint a picture of this melody  
it would be a violin without its strings*

(Newkirk & Mann, 2005)

In listening to participants' stories, I found that the cancer survivors' stories were similar and also different. Some of their experiences could just as well have been mine. I found that the cancer survivors had an attitude of hope and resilience in spite of the challenges that they faced, living with cancer. In this concluding section to my dissertation, I share some reflections on my journey in this research project, starting with how I experienced the interviews, found my own voice, how the field work elicited memories from the oncology ward, to the ethical choices and decisions I had to make.

### *i. The interviews*

Conducting interviews with people who mirror some of the things one experiences as a cancer survivor oneself is challenging. I had to detach myself from the stories they told. I did this, as suggested by Okun and Kantrowitz (2008), by spending time developing my self-awareness and examining my apparent and underlying motivations for the study. At first, it was difficult to distance myself and I caught myself talking a lot. When I listened to the recordings afterwards, I real-

ised that I may have used too much self-disclosure. I decided that I had to approach the self-disclosure slightly differently and in my mind more appropriately. I read the recommendations by Okun and Kantrowitz (2008) on appropriate disclosure during interviewing. Therefore, from the third interview onwards, I changed into an active listener and only used self-disclosure to further the participants' exploration and self-understanding, as recommended by Okun and Kantrowitz (2008).

The most difficult interview I had was the last one. The participant experienced what all cancer survivors fear most, the return of the cancer (Ahmad, 2013; Deimling, Bowman, Sterns, Wagner & Kahana, 2006). I listened to her story and had to let go of my own perceptions and what I felt in order to gain perspective. I hoped that for her, telling her story might have been a way to relieve her from the fears and concerns she experienced. I recently heard that she passed away shortly after the interview and was deeply saddened by this news. I will, however, always remember her for her courage, humour and ability to make a difference in other people's lives.

#### *ii. Finding my own voice*

Through the participant's stories, I discovered some of myself through inner dialogue and the conversations I had with the participants. During my inner dialogue I had many thoughts. I thought about the illness called cancer and I challenged myself in asking the question, "Am I dying from cancer or am I living with cancer?" Hearing the participants' stories helped me to question my own priorities, what I felt was really important in life, and to question the things that I worried about.

I have great admiration for the participants who shared their experiences with me and although these stories were like "a painting of a violin without its strings" (Newkirk & Mann, 2005) I was encouraged by the available support in the workplace so that these cancer survivors never had to feel isolated and alone in travelling this recovery journey.

#### *iii. Visiting oncology*

Visiting the oncology department to recruit participants brought back many negative memories. It was the same place where I had received chemotherapy and

radiation and the memories of the emotions and fear I had, waiting in the reception area, came back to me. Seeing people waiting and wondering what they were experiencing at that moment made me sad and I could not wait to get out of there. Only one participant was recruited at the oncology department. The rest of the participants were recruited at a cancer support institution.

#### *iv. Ethical considerations*

I am committed to an ethical research project. Harrington (2001) quotes Janesick who states that qualitative researchers should allow for the possibility of ethical dilemmas and problems.

Various things happened that elicited new reflections, such as using conversations with some participants, with others interviews and then in other situations just asking them to tell me about their experience when they returned to work and letting the participant tell the story with minimum interruptions. When I started the “interview” with some participants, they reacted in anticipation of a question-and-answer session and in these cases I had to use more of an interview style. In other cases, the participants talked freely about their lived experiences and I could just listen attentively and probe a few times to encourage more sharing. It happened that they talked for the major part of the interview about their actual cancer experience and I felt that I could not deny them that chance to release some of the emotion and tension they felt. It was sometimes difficult for me to steer the conversation back to the workplace experience.

I wondered about the “power relationship” where I could be cast as the “expert” and whether introducing my ideas would result in the participants only telling me what they thought I wanted to hear (Harrington, 2001). I also realised that in some instances it was ethical to provide an input but to be transparent about it (Elliot as quoted in Harrington, 2001). As a cancer survivor, I felt that by giving my input where it was needed, my story became theirs and their story became mine and we could co-construct the meaning of RTW. However, I did not do member checks after I transcribed their stories for the following reasons, as offered by Angen (2000), Morse (1994) and Sandelowski (1993):

- Member checking relies on the assumption that there is a fixed truth or reality that can be accounted for by a researcher and confirmed by a respondent.
  - From an interpretive perspective, understanding is co-created and there is no objective truth or reality to which the results of a study can be compared.
  - The process of member-checking may lead to confusion rather than confirmation because participants may change their mind about an issue, the interview itself may have an impact on their original assessment, and new experiences (since the time of contact) may have surfaced.
- The participants may disagree with my interpretations. Then the question of whose interpretation should stand becomes an issue.
- The participants may have different views of what is a fair account.
- The participants strive to be perceived as good people; I strive to be seen as a good scholar. These different goals may shape findings and result in different ways of seeing and reacting to data.
- The participants may tell stories during an interview that they later regret or see differently. The participants may deny such stories and want them removed from the data.
- The participants may not be in the best position to check the data. They may forget what they said or the manner in which a story was told.
- The participants may want to be 'good' respondents and agree with an account in order to please me.
- Different people may have different views of the same data.

I also wondered if the participants benefited by sharing their experiences with me. I asked one of them how she felt after the interview and she said: "*Dit was lekker om met iemand wat self die pad geloop het, te gesels*", translating into, "*It was nice to talk to someone who has also been there.*" Another participant said it would be great if others could benefit by her experience.

As an introduction to the interviews, I encouraged them to answer or to tell only those parts of their stories that they felt comfortable with sharing, thus protecting their vulnerability and dignity (Terre Blanche *et al.*, 2006). The interviews were very informal and this lent itself to easiness and openness between me and the participants (Harrington, 2001).

## **7.7 A LAST THOUGHT**

The research process ends here, but I would like to take this study further in working together with the various cancer support groups in facilitating cancer survivors' RTW process. I envisage different forms of doing this. One way would be to act as a facilitator in the process and secondly to create awareness through sharing information about the wellbeing of cancer survivors when they RTW with all the stakeholders. This might be done through workshops or meetings.

I hope that the reader of this dissertation will give meaning to it, that it will have meaning and value for each one who reads it. The contributions came from all the different voices that came together in this study and I hope you, the reader, will be enriched by it.

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