THE BUDDHIST COPING EXPERIENCES OF BREAST CANCER SURVIVORS: A PHENOMENOLOGICAL APPROACH

LAI OI LING

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Abstract

Background

Breast cancer is the most common cancer amongst women in Hong Kong, with an incidence rate of one in sixteen. A cancer diagnosis is a life-changing event, and the impact of breast cancer disrupts daily lives in multiple ways. Religion and/or spirituality can provide a means to cope with stress and the fear of recurrence.

Objective

This study aimed to explore the spiritual impact of Buddhist beliefs on women's lived experience of breast cancer survivorship in Hong Kong.

Design

The qualitative study is influenced by phenomenology. Ten women aged between 41 years to 80 years who had survived breast cancer were recruited. A total of 20 semi-structured, in-depth and face-to-face interviews were conducted in the community.

Analysis

The analysis of data was undertaken in two ways, a broad thematic analysis and a second in-depth analysis influenced by Max van Manen. The researcher identified salient themes relating to lived space, lived body, lived time and lived human relations. The study participants' unique stories of their lifeworld reflected the wider context of healthcare in Hong Kong.

Findings

New knowledge was generated, including the 'lifeworld' essences which reflected suffering that transcended words, and gratitude for the support of others. Four Buddhist coping patterns were identified, these were: (a) Transforming their negative karma, (b) Opening up own Buddhahood, (c) Fulfilling the Bodhisattvas identity, and (d) Hope and future. All of the women involved mentioned about the sacred chanting time constituting a peaceful and comfort space of dwelling and therefore enhancing the posttraumatic growth and spiritual well-being.

Conclusion

Searching for the meaning of life is important in helping women better cope with adversity when living with cancer. Cancer survivors can use religion and/or spirituality define their ultimate goals in life and explore the significance of their faith, which empowers them to achieve happiness in their own unique way.

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Glossary

Being: The nature of “being” is determined from within the horizon of time. (Gadamer, 1994, p.257)

Belonging: The meaning of "belonging"- i.e., the element of tradition in our historical-hermeneutical activity - is fulfilled through the commonality of fundamental, enabling prejudices. (Gadamer, 1994, p.295)

Daimoku (Nam-myoho-renge-kyo): This is the Nichiren Daishonin's Buddhist practice and is the ultimate Law or true essence of life permeating everything in the universe. The mantra he expounded on 28 April 1253, known as the *Daimoku* or *Odaimoku*, Namu-Myōhō-Renge-Kyō, expresses his devotion to that body of teachings in terms of each component:

Nam is the act of summoning Myoho-renge-kyo from within us and putting it into practice in our lives and environment by chanting Nam-myoho-renge-kyo.

Myoho is the power of revitalisation, the emergence of the highest state of life; the Buddha state from within us.

Renge is the cause and effect of the emergence of our Buddha nature in terms of benefit, happiness and fulfillment.

Kyo is the thread or link of life, connecting everything through sound and vibration: specifically, the sound of the Buddha state, which is Nam-myoho-renge-kyo.

Available from: http://www.sgi.org/about-us/nam-myoho-renge-kyo.html

Dasein: The original form of the realisation of Dasein, which is being-in-the-world. Dasein that projects itself on its own potentiality-for-being has always already "been". This is the meaning of the existential concept of "thrownness." (Gadamer, 1994, p.259, p.264)

Dwelling: This is informed by the following lifeworld constituents as articulated by Husserl and elaborated by Heidegger: spatiality, temporality, intersubjectivity, mood and embodiment. (Galvin & Todres, 2013, p. 76)

Embodiment dwelling: When dwelling is experienced in an embodied way there is a sense of comfort; when mobility is experienced in an embodied way there is a sense of vitality. (Galvin & Todres, 2013, p. 77)

Fo Guang Shan: Literally meaning, "Buddha's Light Mountain" https://www.fgs.org.tw/en/), this is an international Chinese Buddhist new religious movement based in Taiwan. The headquarters of Fo Guang Shan, located in Dashu District, Kaohsiung, is the largest Buddhist monastery in Taiwan. The organisation is also one of the largest charity organisations in Taiwan. The order also calls itself the International Buddhist Progress Society. Founded in 1967 by Hsing Yun, the order promotes Humanistic Buddhist Hsing Yun's stated position within Fo Guang Shan is that it is an "amalgam of all Eight Schools of Chinese Buddhism", including Chan. Available from: https://en.wikipedia.org/wiki/Fo_Guang_Shan

Gohonzon: This is the embodiment of the Law of Nam-myoho-renge-kyo in the form of a mandala. "Go" means 'worthy honor' and "Honzon" means object of

fundamental respect'. The Gohonzon most often takes the form of a paper scroll inscribed with Chinese and Sanskrit characters in black sumi ink. Together, these characters represent life in its highest condition: Buddhahood. Down the centre of the Gohonzon, in characters larger and bolder than the rest, is written: Nam-myoho-renge-kyo Nichiren) ("On Attaining Buddhahood in This Lifetime," WND-1, 3). Available from:
http://www.sgi-usa.org/memberresources/study/2016_intro_exam_study_guide/docs/pp_31-35_Buddhist_Concepts-The_Gohonzon.pdf

Guan Yin Bodhisattva: Avalokiteshvara**:**(Sanskrit: avalokita, "looking on"; ishivara, "lord") Chinese (Pinyin) Guanyin or (Wade-Giles romanization) Kuan-yin, Japanese Kannon, in Buddhism, and primarily in Mahayana ("Greater Vehicle") Buddhism, the bodhisattva ("buddha-to-be") of infinite compassion and mercy, is possibly the most popular of all figures in Buddhist legend. Avalokiteshvara is beloved throughout the Buddhist world, not only in Mahayana Buddhism but also in Theravada ("Way of the Elders"), the branch of Buddhism that does not largely recognise bodhisattvas, and in Vajrayana ("Diamond Vehicle"), the Tantric (or Esoteric) branch of Buddhism.
Available from: https://www.britannica.com/topic/Avalokiteshvara and
http://www.chinabuddhismencyclopedia.com/en/index.php/Kannon_Bosatsu_(Bodhisattva)

Hermeneutic Phenomenology: Hermeneutic Phenomenology tries to be attentive to both forms of its methodology: it is a descriptive (phenomenological) methodology because it wants to be attentive to how things appear, and it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims there are no such things as uninterpreted phenomena. The implied contradiction may be resolved if one acknowledges that the (phenomenological) "facts' of lived experience are always already meaningfully (hermeneutically) experienced. Moreover, even the "facts" of lived experience need to be captured in language (the human science text) and this is inevitably an interpretive process (van Manen, 1990, pp.180-181).

Hong Kong Soka Gakkai International: The Soka Gakkai International of Hong Kong (HKSGI), established on 28 January 1961, is a Buddhist organisation for lay believers. It is based on the Buddhism of Nichiren Daishonin to promote peace, culture, education and to pray for the happiness of humanity and world peace. Through various discussion meetings, cultural and education exchanges and publications, Buddhism is studied with members, who encourage one another and apply the Buddhist teachings in their daily lives.
Available from: www.hksgi.org/eng

Human Revolution: To live genuinely in a way that is true to yourself, you need to carry out your human revolution; that is, to continue to develop yourself at the deepest level, you "conform" with the "standard" of striving for your human revolution, and then you'll most surely be able to live your life in the most meaningful way. “Human revolution” is therefore the term used by second Soka Gakkai President Josei Toda to describe a fundamental process of inner transformation whereby we break through the shackles of our “lesser self,” bound by self-concern and the ego, and grow in altruism toward a “greater self” capable of caring and acting for the sake of others—ultimately all humanity.
Available from:

www.sgi.org/about-us/buddhism-in-daily-life/human-revolution.html

Ichinen Sanzen: Ichinen Sanzen teaches that each of the ten worlds contains the other nine – thus creating 100 worlds in total. This is known as the mutual possession of the ten worlds. Just as Buddhahood contains all nine lower worlds, so each of those worlds contains the potential of Buddhahood. So lets get on with it…Hell, Hunger, Animality, Anger, Humanity, Rapture, An Intermission – reviewing the lower 6 paths, Learning, Realisation, Bodhisattva, Buddhahood.

Available from:

www.buddhastate.com/2012/04/the-ten-worlds-and-their-mutual-possession

Intersubjective dwelling: When dwelling is experienced in an intersubjective way there is a sense of kindship and belonging; when mobility is experienced in an intersubjective way there is a sense of mysterious interpersonal attraction (Galvin & Todres, 2013, p. 76)

Kosen-rufu: This means to widely declare and spread the Lotus Sutra; to secure lasting peace and happiness for all humankind through the propagation of Nichiren Buddhism. More broadly, kosen-rufu refers to the process of establishing the humanistic ideals of Nichiren Buddhism in society.
Available from: www.sgi.org/about-us/buddhism-in-daily-life/kosen-rufu.html

Language: Language is the medium in which substantive understanding and agreement takes place between two people (Gadamer, 1994, p.384)

Mood dwelling: When dwelling is experienced as mood there is a sense of peace; when mobility is experienced as mood there is a sense of excitement or desire (Galvin & Todres, 2013, p. 77)

Mutual possession of the Ten Worlds: The principle that each of the Ten Worlds possesses the potential for all ten within itself. "Mutual possession" means that life is not fixed in one or another of the Ten Worlds, but can manifest itself any of the ten, from the world of Hell to the world of Buddhahood,at any given moment. The important point of this principle is that all beings in any of the nine worlds possess the Buddha nature. This means that every person has the potential to manifest Buddhahood, while a Buddha also possesses the nine worlds and, in this sense, is not separate or different from ordinary people.
Available from:
www.buddhastate.com/2012/04/the-ten-worlds-and-their-mutual-possession

Nichiren Buddhism: This is a branch of Mahayana Buddhism based on the teachings of the 13th century Japanese monk Nichiren (1222–1282) and belongs to the school of so-called "Kamakura Buddhism”. Nichiren Buddhism is a comprehensive term covering several major schools and many sub-schools, as well as several of Japan's new religions. Its many denominations have in common a focus on the chanting and recital of the Lotus Sutra, which is thought to hold extraordinary power. Nichiren Buddhism is generally noted for its focus on the Lotus Sutra and an attendant belief that all people have an innate Buddha nature and are therefore inherently capable of attaining enlightenment in their current form and present lifetime. It is also noted for its hardline opposition to any other form of Buddhism, which Nichiren saw as deviating from the Buddhist truth he had discovered.

Available from: https://en.wikipedia.org/wiki/Nichiren_Buddhism

Personal identity dwelling: When dwelling is experienced as a form of personal identity there is a sense of being at 'one with' the world; when mobility is experienced as a form of personal identity there is a sense of 'I can'. (Galvin & Todres, 2013, p. 77)

Prejudice: This means a judgment that is rendered before all the elements that determine a situation have been finally examined (Gadamer, 1999, p. 270)

Qigong: This is a holistic system of coordinated body posture and movement, breathing, and meditation used for the purpose of health, spirituality, and martial arts training. With roots in Chinese medicine, philosophy, and martial arts, qigong is traditionally viewed as a practice to cultivate and balance qi (chi), translated as "life energy".
Available from: https://en.wikipedia.org/wiki/qigong

Spatial dwelling: When dwelling is experienced in a spatial way one has a sense of being at home; when mobility is experienced in a spatial way one has a sense of adventure (Galvin & Todres, 2013, p. 76)

Tai Shan Charitable Association: This is a charitable cancer organisation which provides free Chinese Medicine consultation for the cancer patients. Available from: http://www.taishan-international.org/

Temporal dwelling: When dwelling is experienced in a temporal way there is a sense of being grounded in the present moment; when mobility is experienced in a temporal way there is a sense of temporal 'flow' and forward movement (Galvin & Todres, 2013, p. 76)

The Lotus Sutra: The Lotus Sutra is widely regarded as one of the most and influential sutras, or sacred scriptures, of Buddhism. In it, Shakyamuni expounds the ultimate truth of life to which he was enlightened. The sutra's key message is that Buddhahood, the supreme state of life characterised by boundless compassion, wisdom and courage, is inherent within every person without distinction of gender, ethnicity, social standing or intellectual ability. The Lotus Sutra is a teaching that encourages an active engagement with mundane life and all its challenges. Buddhahood is not an escape from these challenges but an inexhaustible source of positive energy to grapple with and transform the sufferings and contradictions of life and create happiness. As SGI President Daisaku Ikeda has proclaimed, the Lotus Sutra is ultimately a teaching of empowerment. It "teaches us that the inner determination of an individual can transform everything; it gives ultimate expression to the infinite potential and dignity inherent in each human life."

Available from: http://www.sgi.org/about-us/buddhist-lineage/lotus-sutra.html

Three Thousand Realms in A Single Moment of Life: (Japanese: ichinen sanzen): This is a philosophical system established by T'ien-t'ai of China that is based on the Lotus Sutra. The "three thousand realms" indicates the varying aspects and phrases that life assumes at each moment. At each moment, life manifests one of the Ten Worlds. Each of these worlds possesses the potential for all ten within itself, thus making one hundred possible worlds. Each of these hundred worlds possess the ten factors and operates within each of the three realms of existence, thus making three thousand realms. In other words, all phenomena are contained within a single moment of life, and a single moment of life permeates the three thousand realms of existence, or the entire phenomenal world. (Adopted from: Ikeda, D. (2016) *Harmony*. HKSGI April pp. 32-40.)

Time and care: Greatly influenced by Bergson and Husserl, in 1927 Heidegger proposed that Dasein has its being in time. Its **horizon** is time. First, time is structured into CARE.

(1) **Thrownness** - Dasein is already in the world, dealing with what it receives from the **past**.

(2) **Projection** - It now lives its projections onto **future** possibilities, Dasein is always "ahead of itself". It is never entirely "all there at this moment" because its being encompasses its “not-yets” as projections.

(3) **Fallenness** - Dasein is pre-occupied with the world in the **present**, dealing with its concerns as they arise, in the particularised **nows** of the ready-to-hand and the them-world.

(Collins & Selina, 1999, p. 79)

Translation: When a translation is necessary, the gap between the spirit of the original words and that of their reproduction must be taken into account. It is a gap that can never be completely closed. Where there is understanding, there is not translation but speech. Similarly, the translator must preserve the character of their own language, the language into which they are translating, while still recognising the value of the alien, even antagonistic character of the text and its expression. (Gadamer, 1994, p.384, p.387).

Abbreviations

Daimoku: Nam-myoho-renge-kyo

EGFR: Epidermal Growth Factor Receptor

FGS: Fo Guang Shan

HER-2: Human epidermal growth factor receptor 2

MBSR: Mindfulness-based Stress Reduction

SGI: Soka Gakkai International

UWE: University of West of England

Quotes from the Lotus Sutra

Chapter 16: The Life Span of the Thus Come One

At all times I think to myself:
How can I cause living beings
To gain entry into the unsurpassed way
and quickly acquire the body of a Buddha?

Soka Gakkai translated by Watson, B. (2009). *The Lotus Sutra and Its Opening and Closing Sutras*. Japan: Soka Gakkai. p. 273.

Chapter 1: Introduction

1.0 Chapter Overview

In this chapter, I introduce the rationale for the present study conducted on the Buddhist coping experiences of female breast cancer survivors. A phenomenological approach to research design and methodology has been undertaken to address this. A rationale for the study is thus given, and the gap between Western and Eastern religious experiences is discussed. Nursing is defined and situated within caring as 'helping'. As a professional nurse and researcher, the provision of a simple description of nursing care is insufficient to demonstrate my concern regarding addressing a patient's beliefs and culture. The chapter concludes with an overview of the thesis and provides an outline of the contents of all seven chapters in the thesis.

1.1 Background and Rationale for the Study

Cancer is an illness and disease that has multiple and complex meanings for the people who suffer from it. Given that drugs and other existing biomedical treatments are not always successful in either the cure or long-term management of cancer, people have resorted to alternative therapies that make sense to them or that help to improve their sense of wellbeing, even if the evidence base for these methods is lacking.

This thesis therefore explores the themes of psychosocial stress and coping experiences amongst cancer patients who engage in Buddhist beliefs in their daily lives. Currently, there is a significant public health and personal challenge in Hong Kong, given the increasing numbers of cancer patients; for example, there were 31,468 new cases reported in 2016, and the first leading female cancer was breast cancer (26.6%) (Hong Kong Cancer Registry, 2018). Importantly, though, despite this ongoing rise in the number of cases, survivor rates are also increasing, which indicates that a significant number of women are living with long-term consequences after the treatment process. In Hong Kong, there are 16 hospitals that provide oncology services. In addition, Christian Chaplaincy Pastoral Care Unit and Catholic Pastoral Care Unit services address the psychological and spiritual needs of patients (Hospital Authority, 2014). There are more than one million followers who pay respects to the Shakyamuni Buddha, Guan Yin Bodhisattva (the Buddhist Goddess of Mercy) in Hong Kong (HKSAR Information Department, 2016). However, there are only a few Hong Kong hospitals that provide Buddhist Spiritual Care Services at this time (Hospital Authority, 2014). Recent research has explored the application of the Buddhist concept of mindfulness to the Mindfulness-Based Stress Reduction Programme, which aims to improve mental health and reduce the symptoms of stress and anxiety (Fjorback *et al*., 2011; Carlson *et al*., 2015; Carlson, 2016). The exploration of the role of faith in the experience of living with breast cancer is therefore relevant in the context of Hong Kong.

1.2 The Gap Between Western and Eastern Religious Experiences

The UK Cancer Reform Strategy has announced a National Survivorship Initiative that has identified a need to support people with breast cancer (Breast Cancer Care, 2017). Breast Cancer Care (2017) provided the ‘Moving Forward’ course and the BECCA free app to share ‘living with cancer’ experiences. The influence of patient advocacy is also particularly pronounced in United States (US) support groups such as the National Breast Cancer Coalition, which have had a direct impact on the research agenda (Alfano *et al*., 2018). For example, the researchers in the Macmillan Listening study invited cancer patients as co-researchers to explore their views and attitudes towards research (Okamoto *et al*., 2012). The study by Brett *et al*. (2010) separately has shifted the research agenda from the causes of breast cancer towards a greater concern regarding the sufferer's interests and needs. Young-Afat *et al*. (2017) focused on breast cancer patient–reported outcomes in long-term (10-year) survivorships, which should aim to achieve a good quality of life (QOL), functional role, and cosmetic satisfaction. In relation to existential perspectives, scholars have explored religious coping in relation to control, identity, psychosocial well-being, and meaning (Kaiser, 2008; Schreiber and Brockopp, 2012; Cheung and Delfabbro, 2016).

However, we also need to focus on the differences, if any, between Western and Chinese cultures in terms of the spiritual or religious faiths of breast cancer survivors. For example, Goldblatt *et al*. (2013) conducted research involving 11 Muslim and 9 Christian Arab women with breast cancer and found their experiences focused on faith in God, which had a significant impact on their family and led them to discover new meaning in their lives following recovery. These women were deeply spiritual in terms of the time and effort involved in expressing their commitment to their understanding of God. This was embodied in the time allocated for prayer, for reflection, and for creative expression and in the perceived greater self-understanding and acceptance. Many research studies on the issue of cancer experiences and religious coping have been designed according to Western culture and mainstream religious Protestant and Catholic beliefs; as such, there is a knowledge gap regarding the cultural and spiritual beliefs of Chinese women, a gap that this study aimed to address in order to provide a nuanced understanding of these concepts in this population.

Previously in Hong Kong, Simpson (2005) researched Chinese families where the women had breast cancer and believed in Confucianism, Taoism, Buddhism, and Christianity. Religion played a significant role in these individuals' adaptation strategies. Cheng *et al*. (2013) studied the role of fatalism by way of conducting 29 interviews with Chinese women and found that participants believed in fatalism and accepted their inability to change the final outcome of cancer. Hamilton *et al*. (2015) determined in another study that spirituality and social support were helpful psychological coping resources and that faith communities have offered social and emotional support in times of need. Therefore, understanding cancer survivors' religious experiences could help clinical practices to facilitate patient coping and adjustment in the early stages of the disease.

Despite the emergence of public health and social sciences research (both qualitative and quantitative) that explores cancer patients' experiences

(Young-Afat *et al*., 2017), no study to date has investigated such in the context of Buddhist breast cancer survivors, taking into account a more 'Eastern' perspective on cancer, religious coping, and lived experiences. Therefore, this study boasts its own unique social and cultural context, in that it is the first qualitative study of Buddhist coping experiences in Hong Kong.

1.3 The Research Question

The following research question was designed to explore the understanding of patient’s lived experiences, feelings, and their concerns regarding suffering cancer in Hong Kong: how do Buddhist beliefs impact the lives of women with breast cancer?

1.4 The Research Aim and Objectives

Aim

The present research aims to explore the lived experiences of women with breast cancer in order to elucidate the impact of Buddhist beliefs on coping strategies.

Study Objectives

The following study objectives were established for this research:

1. To explore the experiences of living with breast cancer by investigating patients’ knowledge, understanding, perceptions, and experiences of their disease so as to better understand these aspects.

2. To consider the role of Buddhist religious beliefs and the spiritual impact of these on Chinese women who have survived breast cancer.

1.5 Defining Nursing for the Purpose of This Study

Oncology patients may experience anxiety related to uncertainty, loss of hope, and a change in their self-concept and body image, affecting their QOL (Erol Ursavas *et al*., 2014). In the United Kingdom (UK), the National Cancer Survivorship Initiative was developed to help people living with cancer lead a more healthy and fulfilling life, with a focus on their well-being and a holistic understanding of their needs. Health care professionals need to be aware of their client's readiness, their coping mode, and their acceptance level in order to better facilitate effective communication (both information-giving and information-receiving).

Nursing is a caring profession that is well-placed to explore the lifeworlds of women with breast cancer, and there is an argument that emerges from this thesis of that Buddhist forms of coping and spiritual expression may be instructive in both socioeconomic and cultural contexts, given the West's renewed focus on psychosocial wellbeing. Exploring the nature of well-being and suffering will provide a more comprehensive understanding. An embodied relational understanding refers to the context of the individual's relationship with others (Galvin & Todres, 2013). Galvin and Todres (2011) focused on the meaning of care, which refers to lifeworld-led humanised care rather than patient-led care. The Supportive Care Nursing Clinical Protocol (SCNCP) advocated that the holistic care in serious ill hospitalized patients be grounded in a comprehensive belief system that cares for mind, body, and spirit (Teal *et al*., 2018).

The role of the Clinical Nurse Specialist is important in a patient's cancer journey. A core capacity of nursing is open-heartedness, involving an understanding of the infinity of otherness and the multiple possibilities for acting in humane and caring ways (Galvin & Todres, 2013). This will help patients to strengthen their power and identify further aspects to explore with regard to how social support could promote the sustainment of hope in their cancer journey. There is limited knowledge about Chinese breast cancer survivors' adjustment using Buddhist experiences. This study therefore sought to provide insight into a comprehensive value base for considering cultural and religious elements in caring systems and the interactions between care providers and patients. Nurses in both Eastern and Western settings could therefore develop more flexible and personalised care plans in an attempt to better understand patients' lifeworlds in the context of Hong Kong.

1.6 The Use of Terms in This Study

Buddhist Beliefs: Buddhism as a belief system began approximately 2,500 years ago. The Shakyamuni Buddha sought to uncover a means to end human suffering, a quest that led him to attain enlightenment, awakening him to the true nature of life (Ikeda, 2014). The Shakyamuni Buddha taught the principles necessary to be followed in order to attain a vast and expansive state of absolute happiness (Ikeda, 2014). Although Buddhism incorporates many different schools, Buddhist beliefs are universally founded on principles of karma and teachings designed to reveal our inherent Buddha nature, regardless of the school. Karma refers to the way a person's thoughts, words, and actions determine his/her destiny in his/her next incarnation and retribution; human revolution transforms our karma by carrying out the Buddha's intent, which plays out in the realm of cause and effect (Zatt, 2016). Research participants for this study were therefore required to have Buddhist beliefs, regardless of whether or not they practice Buddhism daily.

Coping: Coping is a response to stress and is defined as the cognitive and behavioural efforts needed to manage specific demands through stress, appraisal, and coping processes (Lazarus and Folkman, 1984; Thomsen *et al*., 2010).

Breast Cancer Survivor: The National Coalition for Cancer Survivorship (NCCS) defines a cancer survivor as ‘any person living with cancer at any time’ (Emanuel *et al*., 2010). The individual is generally diagnosed with cancer at the acute phrase and has completed primary treatment; they are then considered to be a survivor until the end of their life. This is a dynamic process involving a transition from the acute to the chronic dimensions of illness (Feuerstein, 2007). Stages of survival include acute, extended, and permanent, and these encompass various residual problems they may face regarding their medical, functional, economic, social, emotional, and health statuses (Feuerstein, 2007). Those diagnosed with breast cancer in Hong Kong who were treated either in a private or in public health care system were included in this study.

1.7 Thesis Construction

The present thesis is made of up seven chapters. Sometimes, information is presented in tables, figures, or boxes to provide clarification on and/or to summarise the main points. The references and appendices provide links to further relevant information where appropriate.

Chapter 1 provides a global overview of breast cancer, a rationale for the present study, and an introduction to the concept of nursing.

Chapter 2 presents a literature review and a critical appraisal of relevant research. The Lazarus and Folkman coping model is employed to discuss the experiences of uncertainty and stress in the context of physiological, psychological, and socio-cultural aspects. The existing limitations and breath of the knowledge gap about breast cancer coping issues are addressed according to the different perspectives of 10 selected papers. Furthermore, the Mindfulness-based Intervention and Mindfulness-based Cancer Recovery concepts are introduced. Finally, the chapter identifies where gaps exist and justifies the need for this research.

Chapter 3 focuses on the philosophy of phenomenology and the methodological rationale for this study. As both a qualitative and phenomenological study, I have chosen to write this thesis largely in the first person, as it includes aspects of reflexivity regarding the research design. The concept of hermeneutics is considered, along with how this is understood from Martin Heidegger's and Hans-Georg Gadamer's perspectives. Furthermore, the translation issue is highlighted; I clarify and justify the choice of two analytical, interpretative frameworks; and the hermeneutic circle are shown to be essential in understanding the participants' unique stories. The importance of hermeneutic reflection and interpretation in understanding Buddhist coping experiences regarding their historical meaning for participants is also explained.

Chapter 4 includes the research design and the choice of hermeneutic phenomenology in understanding breast cancer survivors' experiences. The method of data collection includes the sampling strategy and the difficulties involved in the recruitment process. The researcher's liability is considered regarding data protection, ethical considerations, and risk assessment. The arrangement of interviews is considered in detail including the locations used, the choice of spoken language, and the formulation of two interview questions. Furthermore, the data analysis process includes two phases that represent thematic analyses: the van Manen hermeneutic interpretation for meanings and the idea of hermeneutic phenomenological reflection. Helen's stories demonstrate the coding and data analysis process described in six phases. Finally, the chapter addresses trustworthiness in this study through an explanation of the rigorous procedure followed.

Chapter 5 showcases the findings in two sections. The first section presents the participant's unique experiences and the thematic maps of 10 breast cancer survivors. It also includes the summary table of identified themes regarding the van Manen hermeneutic interpretation of a participant's lived world. The data are supported by verbatim quotes to add to the credibility and validity of the study. In the second section, a thematic map of ‘shared experiences’ addresses four key themes. Examples of shared experiences of ‘I am Buddhist’ illustrate how to develop in data interpretation process. There is also highlighted chanting included that constitutes the space and time required to achieved enlightenment and well-being.

Chapter 6 ensures that the meaning of living with breast cancer is understood from the point of view of women's Buddhist faith. A critical discussion of the findings is presented in relation to the literature review. New and original contributions to the knowledge-base that are linked with women with breast cancer are included. Finally, the strength and limitations of the study are considered, and future research and practical suggestions are proposed.

Chapter 7 concludes that the overall aim of the research has been achieved and supported with the key findings. Furthermore, the chanting effect is highlighted from the women's perspective that constitutes spiritual well-being and which strengthens their posttraumatic growth.

1.8 Chapter Summary

This chapter introduced the research topic and the rationale of the study. The research aims to explore how Buddhist beliefs and practices have influenced women's lived experiences in their cancer journey of recovery. The thesis construction provides a broad overview of the below seven chapters. Chapter 2 will now introduce a literature review that provides the insight needed to develop an appropriate methodology.

Chapter 2: Literature Review

2.0 Introduction to the Literature Review

In this section of the chapter, I summarise the evidence available to address the research questions posed by this study. As a reminder, the principal research question was: how do Buddhist beliefs impacts the lives of women with breast cancer?

Additionally, the subquestions were:

- What is already known about the lived experiences of breast cancer survivors?
- Where are the gaps in the current literature regarding the religious coping experiences of women with breast cancer?

The initial review of the literature was limited to the EBSCO and CINAHL databases, which included a search for key terms (Religio* AND breast cancer AND women experiences) in articles published from 1996 to 2013. A second review of the literature was completed in December 2016, considering keywords such as 'Buddhist coping', 'breast cancer survivors', and 'Chinese' used in articles published between 2005 and 2016. A gap was identified around cancer and faith from a more socio-cultural perspective and I followed that up in October 2018 (Appendix A).

2.1 An Introduction to the Cancer Survivor

Breast cancer is the most prevalent cancer amongst women (American Cancer Society, 2017; US Cancer Statistics Working Group, 2016; Petree, 2016). The term ‘cancer survivor’ was first described by Dr. Fitzhugh Mullan, and the NCCS defined the period of survivorship as that starting from the initial point of diagnosis through the rest of a person’s life to the end (Morris *et al*., 2014; NCCS, 2016). A survivor identity helps to ensure active and positive engagement with peers who have experienced the same event (Morris *et al*., 2014). Self-identifying as a cancer survivor might therefore lead to better psychosocial adjustment, positive life changes, and posttraumatic growth (Cheung and Delfabbro, 2016). There is still a lack of consensus, however, regarding how best to define a cancer survivor (Cheung and Delfabbro, 2016).

Cheng and Delfabbro (2016) pointed out that being a cancer survivor was a form of self-identification that facilitated a more positive understanding of ‘who I am’ during long-term survivorship. Smith *et al*. (2016) suggested that the meaning of ‘survivor’ included characteristics or expressions such as factual, victor, functional, temporary, adversity, passage of time, and luck in the survivorship identity. Adopting a survivor identity elicits a possible changing of the self-concept with the passage of time, which is not related to socioeconomic or cancer-related variables (Morris *et al*., 2014; Smith *et al*., 2016). Cheng and Delfabbro (2016) found that 77.9% of women affected by breast cancer are more likely to adopt a survivor identity in comparison with men who have had prostate cancer (30.6%). Many women embrace the identity of being a survivor and adopt a positive image marked by traits or feelings such as triumphant, happy, and healthy (Kaiser, 2008; Deimling *et al*., 2007). Notably, the world-famous cyclist Lance Armstrong was inspired by Albert Schweitzer's words suggesting that cancer instigated a turning point and that suffering took on a special meaning in terms of preparing for works of service that would help and assist in engaging with other people (Frank, 2003).

How, therefore, does the transition from the identity of being a cancer patient to one of being a cancer survivor take place? Transitioning from a cancer patient to a survivor means a significant alteration in the individual’s role from a passive victim to an active fighter against cancer (Bartels, 2009). Cheung and Delfabbro (2016) found that people’s attitudes towards being a cancer survivor could be categorised as embracing, constructive, ambiguous, resisting, and nonsalient. The transition from patient to survivor additionally included accepting the survivor identity, distancing one’s self from survivorship, and survivorship as a nonsalient framework (Kaiser, 2008). Importantly, the transition from patient to survivor should be addressed as much as possible so that people can go back to leading normal lives.

Despite advances in medical technology, cancer patients still often suffer the uncertainty of facing either life or death (Zwingmann *et al*., 2008; Yoo *et al*., 2014; Ng *et al*., 2015). Ng *et al*. (2015) investigated 221 Malay and Chinese women with cancer was using the European Organization for the Research and Treatment of Cancer (EORTC) Quality of Life Questionnaire (QLQ-C30) and the EORTC Breast Cancer-specific Quality of Life Questionnaire (QLQ-BR23) at three time points (baseline, six months, and 12 months) and found that anxiety and depression had no significant changes. Furthermore, cancer survivorship needs to address ways of coping with aging (Runowicz *et al*., 2016). Health-related QOL (HRQOL) is age-dependent, with younger cancer survivors more often having problems in their financial, social, and role functioning and older cancer survivors displaying issues with their physical functioning, respectively (Quinten *et al*., 2015). The majority of European researchers have used the EORTC QLQ-C30 to measure QOL, which is an excellent option for assessing short-term difficulties in cancer patients (Quinten *et al*., 2015).

The Brief Coping Operations Preference Enquiry (B-COPE) scoring system is a commonly used measurement for coping in cancer research (Melton, 2016). Other factors include personality, fatigue, and ethnicity, which have shown positive psychological adjustments with cancer (Melton, 2016). Many physical, psychological, social, and spiritual needs have an impact on patient QOL and change over time across a continuum, requiring significant and shifting resources to address (Mayer *et al*., 2017). As a global phenomenon of a shortage in oncologists and health care workers continues to exist, such shows that survivorship care delivery issues will shift to relying on encouraging and supportive self-care management and assistance from family caregivers, especially for the long-term survivors (Mayer *et al*., 2017). Merluzzi *et al*. (2018) suggested that self-efficacy strategies for coping with cancer include seven domains, as follows: maintaining activity and independence, seeking and understanding medical information, regulating emotions, coping with treatment-related side effects, accepting the existence of cancer/maintaining a positive attitude, seeking social support, and using spiritual coping in the treatment-planning process. The revised Cancer Behaviour Inventory (CBI; version 3.0) offers new spiritual coping subscales regarding self-efficacy in coping with cancer (Merluzzi *et al*., 2018). One aspect of the knowledge gap is that there is not a large number of Asian-specific options to measure long-term EORTC QLQ-C30, HRQOL, and CBI scores. Therefore, the use of a qualitative research design may explore how the long-lasting effects of cancer shape people's coping perceptions and their sense of spiritual well-being to better maintain a good QOL and adequately perform the necessary roles and responsibilities (Hannum *et al*., 2016).

2.2 Culture and Survivorship

Cancer features as a metaphor in Susan Sontag (1983), indicating victim blaming underlying public views of cancer and captured in figures of speech about the illness. It also pointed to cancer as a cultural 'touchstone', the struggles of subjectivity underlying what has been viewed as a transvalued cancer culture (Steinberg, 2015). The feminist social semiotic tradition focuses on the - female beauty culture including the fetishisation of the female breast; for example, when the actress Angelina Jolie underwent prophylactic double mastectomy, it was perceived that she bravely coped with her altered body image (Steinberg, 2015). The cultural sociology applied by Swidler defines survivorship as a cultural tool that helps women ‘retool’ their lives following a major life event (Swidler, 1986; Kaiser, 2008). The wider cultural context provides clear guidelines on how to be a breast cancer survivor and how to organise the self and life in a proper way (Kaiser, 2008).

- Frank's suggestion, on the other hand, is that survivorship is defined as a form of craftwork designed to understand the role of women in providing services for others following cancer (Frank, 2003; Kaiser, 2008; Frank, 2013). Culture is a form of self-conscious crafting and of constructing meaning within the socialisation context of living with the community (Kaiser, 2008). Laranjeira *et al.* (2013) pointed out that culture influences how we perceive the world and the self and, therefore, people will engage in construction/reconstruction of their self-identity as needed. Culture in this regard is influenced by cancer-related advertisements and images that shows how the ordinary person becomes a cancer fighter (Steinberg, 2015). Arif (2011) argued that faith and spirituality do not limit themselves to the boundaries of culture and ethnicity, so it is better to conduct life following a single faith rather than trying to navigate amongst different cultures. A few qualitative studies have focused on mood changes across the cancer continuum in terms of how cancer patients from diverse cultures respond to related stressors (Yoo *et al.,* 2014).

Depression cannot be seen and sometimes can be easily hidden by the appearance of the ‘cancer patient with a happy smile’. Even the family and best friends cannot fully understand the inner suffering and suicidal thoughts that may occur. A suicide attempt can happen at the spur of the moment when a patient loses hope. Consideration of mental wellbeing and the behaviour of those with mental health issues fits less well into the social norms in Asian society (Fung, 2018). There is a stigma regarding suicide in China, and women’s suicide rate is higher than that of men at a ratio of 2.5 to 1 because of the former’s lower social status within the culture (Law, 2016). The power of culture is a fundamental force that can transform the human heart and cultivate inner life and spirit (Ikeda, 1999). A depressed person may not attempt to seek medical help because they are afraid of being called ‘crazy’ and that the public may not show any compassion or sympathy with respect to their struggles (Fung, 2018).

Avis *et al.* (2013) examined the age differences of their depressive symptoms. Survey answers were evaluated using the Beck Depression Inventory (BDI) scale at the three time points of six months, 12 months, and 18 months after baseline. Significant predictors of decline in depressive symptoms included searching for the meaning of/peace in life, social support, and completion of chemotherapy with doxorubicin. The strengths of this study included its larger sample size and the fact that few longitudinal studies had examined the age-associated differences in depression worsening or lessening over time after diagnosis. However, this study was an observational study and the BDI was a self-reported measure. The sample was also composed of homogeneous (white and educated) women recruited from Memorial Sloan Kettering Cancer Center in New York, NY only, which limited the generalizability of the results.

2.3 Cancer, Faith and Coping: socio-cultural dimensions

So, how can we make sense of cancer experiences across non-Western cultural contexts? One issue that is of central importance is that of the belief of impermanence, which can be argued is deeply embedded in Eastern culture; for example, the Taiwanese specifically believe that life disturbances are determined by fate (Lin *et al*., 2010). The risks of continual uncertainty can be redefined as a natural rhythm of life and rely on supernatural powers channelled through religious activities (Lin *et al*., 2010). Determining the meaning of control and promoting the acceptance of fate is thus one particular coping strategy that has been employed in Chinese 'culture' more widely (Ching *et al*., 2009). This is not to take an essentialist or even deterministic position on cultural experience and motifs, but to suggest that some common features (and discourses) of a cultural system may shape public and private experience. These are cultural systems that shift over time and are socially and cultural constructed: that is, they are historically and culturally situated (Berger and Luckman, 1966; Searle, 1996).

Religious/spiritual faith as a coping mechanism for patients with cancer, for example, has a rich history in Western society (Holland *et al*., 1998; Thune-Boyle *et al*., 2006; Atef-vahid *et al*., 2011; Garlick *et al*., 2011; Powell *et al*., 2013). Critical social thinkers such as Marx argued that ‘man makes religion, religion does not make man’—that is, a self-consciousness of the real world—and also protest suffering, which become ‘the opium of the people’ (Marx and Engels, 1975), and so the view that religious systems can be perceived as social and cultural systems became central to Western intellectual critiques of religious thought and action. These belief systems 'rest not on universal laws, but rather on a wide spectrum of specific 'organic' healing beliefs, traditions, powers and practices. These are by definition idiosyncratic, ethnocentric and culturally specific' (Moore and McClean, 2010: 23).

Religion can be defined as one amongst many different and competing ‘world view’ that is acted out in many formats such as narratives, doctrines, symbols, rites, rituals, sacraments, and gatherings that promote mutual understanding and obligation (Gilbert, 2011), and its presence and meaning varies significantly across cultures (Morris, 2010). Religious and spirituality belief also plays a significant role in human behaviours and motivations (Speed, 2017). Religious beliefs and practice can strengthen coping strategies in the face of suffering in a way similar to that of considering respected religious figures such as Jesus, Muhammad, and Mother Teresa (Abu-Raiya and Pargament, 2015). Religion often serves a social function to shape an individual’s reality through the process of transvaluation and further divert people's attention from the social suffering and other more worldly concerns (Kleinman, Das and Lock, 1997; Swatos, 2018). Christianity is an example of a salvation transvaluation that God's grace can save people. Consideration of faith, coping and care have also featured prominently in sociological analysis of cancer experience, and there are noted similarities between religious/spiritual beliefs and the lay models of illness causation (Kerr *et al*., 2018).

Psychological and psychosocial research has focused on the impact of religion on the health and well-being of the individual (Gall *et al*., 2009; Abu-Raiya & Pargament, 2015). McIntosh *et al*. (2011) examined the association between health and religious participation during the three years following the September 11, 2001 terrorist attacks. Most (70.7%) respondents identified as Christian, and the researchers found that greater participation in religiosity and spirituality predicted lower incidences of musculoskeletal and mental ailments and fewer cognitive intrusive thoughts around the traumatic event (McIntosh *et al*., 2011). Historically, faith-based organisations play a significant role in promoting spiritual well-being in American communities (Brown and Cowart, 2018). The documented benefits of attending church include not only the provision of social support but also the adoption of a healthier lifestyle (Speed, 2017). This shows the continuous positive influences on coping that connecting people in the church who provide support and information can have. Social support was perceived as an important factor in being able to adapt to living with changes following a cancer diagnosis (Knobf and Erdos, 2018).

Individuals with low religious involvement are often perceived at greater risk of death, with some even feeling anger toward God, which is associated with poorer mental health and decreased psychological adjustment (Caple *et al*., 2014). The existing evidence also supports the thought that religious practices make positive contributions to cancer survivors' QOL (Canada *et al*., 2016). The question to answer, however, is regarding how this occurs - what mechanisms underpin this? Faiths often focus on a connection with God in Western countries that significantly overlap with regard to existential and the meaning of life (Thune-Boyle *et al*., 2011; Abu-Raiya and Pargament, 2015).

Conceptually religious coping encompasses religious beliefs, religious practices, attachment to God, and links to indices of physical and mental health (Abu-Raiya and Pargament, 2015). Many research findings show that 'God-focused' coping strategies and 'religious/spiritual mobilization' correlate with higher scores on measures of life satisfaction (Gall *et al*., 2009; Abu-Raiya and Pargament, 2015). Al-Azri *et al*. (2014) identified five coping strategies that individuals may adopt including denial, optimism, withdrawal, use of religious beliefs and practices, and the support of family members and health-care providers.

Spiritual well-being correlates positively with having a fighting spirit and negatively with psychological distress variables such as hopelessness and suicidal ideation among terminal ill patients (Bovero *et al*., 2016; Jimenez-Fonseca *et al*., 2018). Thus, the practice of faith can initiate hope and enhance QOL during coping with cancer, while spirituality can strengthen hope in the face of end-of life despair (Caple and Schub, 2014; Bovero *et al*., 2016; Chaar *et al*., 2018). However, there may be an oversimplified theorized cause-and-effect pathway established between faith and QOL at this time, and we must be careful not to overstate its importance.

Research findings have reported that a two-factor model of the Functional Assessment of Chronic Illness Therapy–Spiritual Well-being Scale (FACITSp) had a statistically stronger correlation with QOL (Canada *et al*., 2016). Current research indicates spirituality plays a vital role in caring for patients with advanced cancer and pushing them to remain hopeful and happy to the point that 'meaning' and 'peace' are highly correlated with better psychological adjustment (Jimenez-Fonseca *et al*., 2018). This highlights that spiritual care improves patient's QOL in oncology and community care (Bovero *et al*., 2016).

After people experience a period of traumatic suffering that may contribute to posttraumatic stress growth, they may identify a new meaning for life and be hopeful towards the future. In this regard, what are the situational and contextual factors that shape patients' perceptions and experiences of life after cancer? Furthermore, Roy's Adaptation Model of Nursing (1984, 1991) posits that humans are biopsychosocial adaptive systems composed of four modes, as follows: physiologic needs, self-concept, role function, and interdependence (Roy and Andrew, 1991; Polit and Hungler, 1995, Ursavas *et al*., 2014). According to this model, adaptation is either increasing, decreasing, modifying, or removing internal and external stimuli in an ongoing process (Roy, 1984). Nurses represent the best advocates to initiate a patient's adaptation concept and coping behaviours that will increase their life expectancy (Ursavas *et al*., 2014). However, the Roy Adaptation Model focuses on how nurses can manage the focal stimulus and the contextual stimuli; therefore, this model is inappropriate to use to study the transition of self-identity in Buddhist coping concepts. Separately, the Lazarus and Folkman transaction-based theory of coping was famous in the academic psychology field and so was employed herein as a theoretical framework to conduct the literature review including regarding physiological, psychological, and social aspects that would enable the exploration of breast cancer experiences.

2.4 The Lazarus and Folkman Coping Model: Theoretical Framework

The importance of coping to the research literature can be seen in its incorporation into models of stress and illness (Thune-Boyle *et al.*, 2006). Stress is the body's reaction to a change that requires a physical, mental, or emotional adjustment or response (Todd *et al.*, 2014). Coping is defined as an adaptation to stressful situations (Rice, 2012). Lazarus and Folkman (1984) argue that coping involves a conceptual effort to redefine the stress; adapt to the situation; and reappraise the perceived threats, which could exists at all three levels (social, psychological and physiological). Adaptation occurs subsequent to coping and includes problem-focused coping and emotion-focused coping, which are affected by individual differences and characteristics of the personality and the environment (Lazarus & Folkman, 1984). Problem-focused coping entails managing or altering the problem in the environment that has caused the distress, while emotion-focused coping involves regulating the emotional response to the problem (Lazarus & Folkman, 1984). Cancer can impact people's values and their relationship with others, and results in a reorganisation of their life priorities (Casellas-Grau *et al.*, 2014). Thus, value clarification, purposeful priority setting, and targeted problem-solving may also be useful techniques for individuals suffering from negative life-changing events (Werner et al., 2012). Problem-solving models therefore help to diminish a patient's sense of helplessness whilst also promoting their optimism, courage, and self-confidence (Nezu et al., 1999). If the stressful events are managed well, both the short-term and long-term adaptational health outcomes are achieved and the result is good health, effective social functioning, and positive morale (Lazarus & Folkman, 1984).

2.4.1 Physiological Aspects of Breast Cancer

Physical well-being is affected by cancer treatment and altered normal daily functioning because of pain, fatigue, and poor sleep quality (Alfano *et al*., 2018). Mastectomy may threaten the feminine identity and can have a lifelong impact in terms of a disruption of daily functioning as well as sexual activity in younger survivors (Male *et al*., 2016). Zhu *et al*. (2013) described the common short-term side effects of postchemotherapy as being fatigue, nausea, vomiting (emesis), stomatitis, alopecia (loss of hair), and myelosuppression (bone marrow suppression). Conversely, long-term side effects often include permanent premature ovarian failure in premenopausal patients and potential cognitive impairment, while some women may also experience myalgias (pain in the muscles) and neuropathy (pain and numbness in the limbs) as a result of damage to the peripheral nervous system (Zhu *et al*., 2013).

Table 1 summarises the treatment-related response and coping according to the aforementioned three levels adapted from Lazarus and Folkman's (1984) and Chan's (2008) research.

Table 1: Treatment-related Responses and Coping in the Three Levels of Analysis Model

	Causal Antecedents	Mediating Processes	Immediate Effects	Long-term Effects
PHYSIOLOGICAL	1. Chemotherapy: Pain at the infusion site, anorexia, nausea, vomiting, constipation or diarrhoea, abnormal taste/smell, fatigue 2. Radiation therapy: Reddening and irritation in areas	Performing role function Family role (mother) Employment responsibilities	Suffering Unemployment No pain	Impaired physiological functioning Recovery from illness Longevity
PSYCHOLOGICAL	Breast reconstruction: Pain at the wound sites Large area of scars Chemotherapy: 1. Loss of hair 2. Loss of libido Hormone therapy: 1. Menopausal symptoms (hot flushes, vaginal dryness/irritation, dry skin, etc.)	Appraisal–Reappraisal Coping: 1. Problem-focused 2. Emotion-focused Environmental variables: 1. Materials, resources 2. Seeking and using social support Person variables: 1. Value-commitments 2. Beliefs	Positive or Negative feelings Quality of life	Coping with psycho-sexual disruptions in womanhood Role function deficits Morale Well-being Functioning in the world
SOCIAL	Post-surgery loss of body part and/or loss of body function	Altered body image Change in self-esteem	Coping with psychosocial inferiority due to body-related deficits	Active social networks Social isolation

2.4.2 Psychological Aspects of Breast Cancer

Psychological well-being is affected by symptoms of anxiety, the fear of cancer recurrence, and postchemotherapy induced problems with memory (Yoo *et al*., 2014; Alfano *et al*., 2018). The diagnosis of breast cancer is one of the most anxiety-inducing and frightening experiences (Alifrangis *et al*., 2011; Shennan *et al.,* 2011; Weitz and Lachman, 2012; Weitz *et al*., 2012; Antoni, 2013). The uncertainty in illness theory defines uncertainty as arising from an individual who does not have sufficient clues to structure an event and thus cannot predict outcomes accurately (Kim *et al*., 2011). It focuses on individual differences regarding structure providers and their stimuli framework (Kim *et al*., 2011). Structure providers include the patient's social support as well as the trust and confidence and the knowledge level of their health care team (Kim *et al*., 2011). The stimuli framework includes the influence of the symptom pattern, event familiarity and event congruence or the consistency of the patient's expectations, and what is actually experienced (Kim *et al*., 2011).

McCorry *et al*. (2013) conducted research to examine the illness perceptions and coping strategies amongst 90 women diagnosed with breast cancer, both at the time of diagnosis (time 1) and at six months after diagnosis (time 2), using questionnaires (Illness Perception Questionnaire—Revised, the Cancer Coping Questionnaire, and the Hospital Anxiety and Depression Scale). The strength of this study was in using the revised questionnaire to explore women's scores of distress before and after surgical treatment. Previous longitudinal research seldom measured illness perceptions prior to treatment. However, there was only a 52.3% recruitment rate, as just 90 of 172 women returned the completed questionnaires by the time 1 requested and only 75 women returned their responses at time 2 (16.67% attrition rate).

Table 2 summaries the findings of five studies on the subject of uncertainty in breast cancer survivors.

Table 2: Concepts of Uncertainty in Breast Cancer Survivors

Author, Year	Research Design	Findings Themes	Inspiration for This Study
Barthakur *et al*., 2016	Descriptive phenomenological approach Semi-structured Interviews with 15 Indian women	Illness, treatment, and side effects Counselling needs Quality of interactions Cultural norms	To explore low-income and less well-educated groups To determine counselling needs in Hong Kong
De Vries *et al*., 2014	Focus group discussion with 27 Dutch women	Distancing Self-controlling Escape-avoidance	The existence of an anxious level of recurrence To seek social support, promote problem-solving, and establish positive reappraisal
Cheng *et al*., 2016	Qualitative interviews with 29 Chinese women living in China	Fear of recurrence Poor body image and altered sexuality and intimacy Financial burden	These socio-cultural factors are key considerations in exploring the perceptions of life changes among the Chinese population
Boehmke and Dickerson, 2006	Heideggerian hermeneutics interview with 30 women from New York	Changing health overnight Erasing of a former self Appraising of illness Approaching the future—now what?	To explore diverse community settings How do women maintain an optimistic attitude when living with cancer?
Lam and Fielding, 2003	Four semistructured and consecutive interviews with 17 Hong Kong Chinese women	Face the threat of diagnosis Living with the uncertainty that is cancer The meaning of surviving breast cancer Re-appraising the priorities in life	How does the loss of a breast affect their marital relationships? Is sexuality or femininity important to self-identity? Is a self-image of 'normality' having power?

Breast cancer is perceived as a traumatic and transformative life event and its existence alters daily life in terms of physical disfigurement, uncertainties, and negative emotions (Chan, 2008). Importantly, what are the factors that influence these depressive and avoidance feelings? Kim *et al*. (2011) argued that age, marital status, pain level, and monthly income were significant predictors for such during and after treatment. It is also interesting to focus on how patients cope with their fear, irrespective of whether cognitive behavioural coping strategies change over time. De Vries *et al*. (2014) recruited survivors with at least a 10-year time span since their treatment, 80% of whom used an emotion-focused coping strategy including 49% of whom selected escape-avoidance, distancing, and self-controlling as part of their protective shield to keep them busy and from thinking about their breast cancer (De Vries *et al*., 2014). Self-distraction was viewed as a positive venting method by women with breast cancer and included the use of humour (Melton, 2016). Further research was proposed, suggesting the use of a longitudinal rather than a cross-sectional design could indicate how uncertainty changes over time and in relation to the different chemotherapy regimens and/or the timing of chemotherapy or radiotherapy (Kim *et al*., 2011). These psychological aspects of breast cancer inspired the recruitment of a more purposive sample to study long-term survivors such as those at five, 10, and 20 years postdiagnosis in order to quantify their uncertainty, existential being, and coping strategies.

2.4.3 Social Aspects of Breast Cancer

Social dimensions of well-being are impacted on changes in relationships with family and employment and financial concerns (Burnham, 2012; Alfano *et al*., 2018). A large proportion of sociological research has studied the experiences of illness and a majority has focused on women’s experiences of living with and beyond breast cancer (Kerr *et al*., 2018). Furthermore, cancer experience may be influenced by inequalities; identities issues following cancer are different and multifaceted depending on socioeconomic status, gender and disability (Kerr *et al*., 2018). There is a focus shift on the ‘make-over’ metaphor and how it can transform a patient's illness identity after reconstructive surgery (Kerr *et al*., 2018). For example, are you healthier, happier, and more moral if you are religious?

- Sociologists are interested in religion as an aspect of group behaviour, such as Durkheim's focus on the collective aspects of comparative religious experience (Morris, 2010) - and with respect to the roles religion has played in the functioning of human societies, in terms of increasing social order and consensus. Religious involvement may have an association with longer life by increasing social contact and support, leading to positive emotions and better social well-being (Gall *et al*., 2009, Gallup, 1995). For example, the faith-based education model is effective in promoting regular mammograms and improving awareness of the need for the early detection of breast cancer (Brown and Cowart, 2018). The concept of ‘being connected’ was described as a sense of caring and comfort, especially in church groups where those who are breast cancer survivors are sisters, no matter what their skin colour is (Knobf and Erdos, 2018).

Cancer is a high concern and has received significant research funding from both the US and UK governments, leading to the identification of three key areas including cancer identity, risk, and the responsibility of patient and practitioner experiences (Kerr *et al*., 2018). Talcott Parsons' theory of structural functionalism defined illness as a deviance (Burnham, 2012), as it left society potentially vulnerable in coping with the individual's withdrawal from societal obligations. The theory of sickness roles signifies how people who get sick have an obligation to receive medical treatment and how the physician acts as a social control agent to grant the temporary sick leave from the social structure (Frank, 2016). A woman with breast cancer defines not only her role as a patient but also the set of functions to which she belongs. Chen *et al*. (2017) pointed out that Chinese women are often the main source of income in their family regardless of their role as a daughter, wife, or mother. For a woman who has become ill with breast cancer, the first concern is still the maintenance of family roles and responsibilities (Frank, 2016). On the other hand, higher anxiety and depression levels were found in those of a younger age, who were single, and who had higher financial burdens among Malaysian Chinese breast cancer survivors (Ng *et al*., 2015).

Fisher and O'Connor (2012) investigated the concept of motherhood in women with breast cancer as guided by a social constructivist paradigm. All who were living with dependent children experienced an identity reconstruction; these included maintaining normality and continuing the mothering role (Fisher and O'Connor, 2012). The mothering role was modified in these young breast cancer patients, as it existed in constant tension with the transition to a survivor status, especially in terms of their responsibilities for the well-being of their children. Younger women (those aged between 30 years and 40 years) were more intentionally focused on maintaining a balance between worrying about the worst outcomes and the efficient incorporation of the diagnosis into their lives (Lally & Underhill, 2012). Care for oneself was perceived as a source of stress in younger women with small children, because the women felt selfish about taking time alone and reducing their commitments to others and to their children's future. The impact of breast cancer on their identities as mothers is complex because they may or may not wish to expose the possibility of death to their children. Young breast cancer survivors largely perceived that their children were too young to understand the concept of death. The current study therefore attempted to recruit participants with a mother role and to understand their role and patterns of identity in their lives.

The Lazarus and Folkman transaction-based theory of coping was therefore employed as a theoretical framework to help develop the first interview questions that would enable exploration of physical, psychological, and social stress and coping experiences. Although existing theories can describe the essence of the stress and coping phenomenon, the Lazarus and Folkman transaction-based theory alone is insufficient to answer the research questions. The second interview questions were thus designed to focus the religious/spiritual coping experiences.

2.5 Identifying Existing Knowledge Gaps in the Literature

The growth of cancer survivorship research has revealed the four domains of survivors' well-being (physical, psychological, social, and spiritual) to address their ongoing needs and functioning (Alfano *et al.*, 2018). The present literature review should therefore extend to breast cancer survivors' religious/spiritual coping experiences from other perspectives. From the searches conducted between October 2013 and September 2018, the following papers were identified, which focused on the religious experiences of breast cancer. The Critical Appraisal Skills Programme (CAPS) and the Consolidated Criteria for Reporting Qualitative Studies (COREQ) were used to critique the data extraction, sample characteristics, and quality assessment of the selected articles (Aveyard, 2014; Tong, Sainsbury, and Craig, 2007). The selected papers were reviewed in terms of the following:

- Whether or not they summarised previous relevant research
- Whether or not they specified how and why the proposed methodology was used

Paper 1: Nelson (1996)

This study explored the uncertainty of women with breast cancer in the US and was guided by hermeneutic phenomenology and a reconceptualisation of Mishel's Uncertainty in Illness Theory (RUIT) (Nelson,1996). It employed a convenience sample that included participants from a local chapter of the American Cancer Society. Nelson's study highlighted a transition process that involved learning new ways of being in the world, considering one's reflections of self in the world, and gaining a better understanding of the uncertainty of life.

This research method was very useful due to its adoption of applied hermeneutic phenomenology and photographic hermeneutics. Hermeneutics is rooted in beliefs and inspired the methodology of this study with regard to religious and spiritual coping. Furthermore, this research provided an excellent example of the symbols that form an important part of personal experiences. In Nelson's study, one participant, Carolyn, used weeds in her yard as a hermeneutic symbol to represent cancer (health), and she was often out in the yard repeatedly pulling up the weeds. These weeds were a symbolic metaphor that provided the researchers with a second interpretation of the uncertainty experience for women.

Few studies have explored the idea of psychosocial adjustment from an individual's view of uncertainty. This study, however, shifted the view from nursing towards exploring the cancer patient's viewpoint, i.e., that of a dynamic and whole human being. In the US in the 1970s, breast cancer patients were not always clearly informed of their diagnosis and the treatment options depended on their physician's judgment; they were seldom involved in the decision-making process regarding surgery (Montini, 1997). The traditional process of informing patients usually involved a lack of feedback from patients and an absence of agreement on information between patients and their health care teams. Sociologists such as Marie Haug, Eliot Freidson, and Bebe Lavin have advocated for the concept of deprofessionalisation, which refers to changes in traditional professions such as medicine (Montini, 1997). Such social movements have strived to promote better client–provider interactions between physicians and patients. There was, at that time, no standardised follow-up model for patients with early stage breast cancer who had completed surgery. Separately, Runowicz *et al.* (2016) identified gaps in cancer survivorship resources and care, especially those addressing the survivor's unique posttreatment needs and later effects. A Survivorship Center was developed to help survivors at the individual, system, and policy levels achieve optimal health and wellness (Runowicz *et al.*, 2016).

Paper 2: Lam and Fielding (2003)

Is the experience of uncertainty influenced by time factors? Lam and Fielding (2003) interviewed 17 young Hong Kong Chinese women and described how shocked they were to face the unanticipated threat of death. The experience of bodily dissonance sensations was perceived as an obstacle to reestablishing normality. Perceptions of cancer have shifted from traditionally viewing it as an acute illness to looking at it as a chronic disease as well as considering how those affected thought they were regarded by other people (McCann *et al.*, 2010). Importantly, the significant changes in appearance associated with a breast cancer diagnosis often led to stigmatization and social exclusion. study inspired certain interview questions including ‘why did the event happen?’ and ‘what does my life mean now?’.

There have been few studies specifically conducted involving the Hong Kong Chinese community until Lam and Fielding’s research was published in 2003. The women studied searched for a new meaning in survival, which involved a fuller appreciation of the everyday things in life and a more mature coping perspective in the context of Chinese culture. Lam and Fielding’s research explored self-identity and coping in terms of subgroup differences among Chinese and Hong Kong women and has proven very useful. Hong Kong Chinese breast cancer survivors felt that the loss of a breast had much less value as a symbol of feminine sexuality than it did in Western culture and would not affect their marital relationships. Lam and Fielding argued that Asian women are thus more likely to undergo mastectomy than Western women and may subsequently also not opt for reconstruction. Sexuality or femininity is less of an issue in Chinese culture because the loss of the breast can be hidden. However, the visible stigma of cancer treatment-induced hair loss, weight gain, and facial changes are more threatening with regard to an adverse effect on their social groups and role functioning in the community. Lam and Fielding therefore argued that a desire to avoid being seen as different was perceived as a personal obligation to maintain social harmony, especially in Confucianism Chinese communities. Therefore, health and sickness were considered to be a societal issue because the perception of an ill body signified the possession of bad luck. More specifically, the cultural belief was that a sick person may bring bad luck to the family.

A positive illness perception would help to acknowledge a patient’s long-term role in adjustment and enable them to modify cultural meanings to fit their lives (Kasier, 2008). Male *et al*. (2016) argued that most breast cancer patients were dissatisfied in that they received inadequate or nonexistent care to address their sexuality health needs (32%–92%) and altered body-image (27%–88%) concerns. It is important to highlight that breast cancer diagnosis universally affronts a women's sexual identity and illness perception; however, health care providers overlooked their unique sexual health needs and their psychological concerns according to their specific ethnicity and culture (Male *et al*., 2016).

A recent study showed that approximately 75% of women with breast cancer experience a decrease in sexuality activity because of a decreased libido, a reduction of one's sense of physical attractiveness, and an altered sexual identity (Male *et al*., 2016). Those women who received radiotherapy, chemotherapy, and hormone therapy reported six-fold increased risks of lubrication and satisfaction disorders, which may influence their intimacy relationship (Male *et al*., 2016). Feilding *et al*. (2013) argued that Japanese breast cancer patients showed greater psychological needs and supportive care needs than did Chinese patients in Taiwan and Hong Kong, which may implicate cultural and/or health care service provider influences. Hong Kong Chinese women adapt to busy life and are eager for normalcy during their fight with cancer, and they tend not to emphasize sexuality and reported having their sexuality needs still met during their illness, a finding that is congruent with those of Lam and Fielding (2003). These Chinese women respected the attitude of their husbands towards any sexual changes (Cheng *et al*., 2016). Importantly, breast cancer support groups can share the patient's experience and encourage the patients, reassuring them they are not alone in facing their cancer. Notably, some people may be shy and embarrassed to talk about sexual implications in front of a group in Chinese culture, so this study chose to conduct face-to-face interviews rather than focus groups as a means of data collection.

Paper 3: Al-Azri *et al.* (2009)

Al-Azri *et al*. (2009), for example, pointed out that Muslim women who accepted their breast cancer diagnosis as Allah's (God's) will experienced decreased feelings of anger and used religion and spirituality as their primary resources for coping. The frequency of mosque attendance promoted positive thinking and decreased a sense of social isolation with praying perceived as a dependence on Allah, who is helping them to navigate their cancer trajectory (Al-Azri *et al*., 2009; Al-Azri *et al*., 2014; Hammoudeh *et al*., 2016). During their emotional stress and pain, some women took to reciting holy words that gave them strength, power, and a sense of peace. In times of stress, Muslims will read the Qur'an (the Muslims' Holy Book) to find consolation and remind themselves to be patient (Ahmad *et al*., 2011; Lally and Underhill, 2012; Abu-Raiya and Pargament, 2015). This inspired the idea of the present research to ask about participants' daily religious practices such as chanting and reading the Lotus Sutra every day.

In the Islamic religion, the word of Allah is not the same as those of God in the Catholic and Protestant religions, and is expressed in the Qur'an. Therefore, Muslims' spiritual life must be based on acts of worship and living the religion as ordained in the Qur'an. In an Islamic context, religion constructs not only rituals but also an inner dimension that governs a 'way of life' regarding politic, social, and economic contexts (Ahmad *et al*., 2011). However, the role of religion and spirituality in the coping and support process has received little attention from health care professionals and in the health care infrastructure (Hammoudeh *et al*., 2016). Both Christian and Muslim women accepted their daily struggles with breast cancer as a test of faith that would be rewarded in the afterlife in the Lebanese culture (Doumit *et al*., 2010; Hammoudeh *et al*., 2016). They observed the illness as an awakening, and peace and strength came from surrendering to Allah (Ahmad *et al.*, 2011). Furthermore, no matter what, they believed they would live in eternal life and experience a final return to Allah (Ahmad *et al*., 2011). The present study was thus inspired by this to explore the idea of life after death and the mutual possession of the 10 worlds in Buddhist faith.

Paper 4: Johnston (2012)

Johnston (2012) explored the potential impact of the Mindfulness-based Stress Reduction (MBSR) programme on the transformation of self-identities in women with breast cancer. Between 30% and 40% of women experienced emotional distress for up to 20 years postdiagnosis due to family stress, financial strain, and personal stigma (Johnston, 2012). Furthermore, threats to self-image and body shame also impacted the discrepancy between the actual and the perceived selves (Johnston, 2012). Mindfulness-based approaches may therefore have benefits regarding acceptance in breast cancer survivors. Five facets of the mindfulness process are observing feelings, nonjudgmental attitudes, describing thoughts, nonreactivity, and acting with awareness of the here and now experiences (Johnston, 2012).

A universal experience of breast cancer survivors concerned changes in body image, which was often the most persistent challenge to perceived femininity and self-esteem (Boquiren *et al*., 2013). Issues included loss of the breast, visible scarring, hair loss, and lymphedema. Body image can be defined as one's thoughts and feelings about one's physical appearance and competence and encompasses a subjective perception of wholeness, functioning, and sexuality (Boquiren *et al*., 2013). Body image is thus both a state of personal expression of being and of dynamic interaction with others in the social world (Boquiren *et al*., 2013). Higgins' Self-Discrepancy Theory explained how people actively compare the actual self and the ideal cultural self and internalise these standards through gender and role socialisation (Leary and Tate, 2010;

Boquiren *et al*., 2013). Thus, if one failed to meet these societal prescriptions or resolve a perceived discrepancy, this led to self-dissatisfaction and shame (Leary and Tate, 2010; Boquiren *et al*., 2013).

A woman's sense of self is often disrupted following treatment for breast cancer due to the symbolic nature of the breast. The changes that can occur to her physical body may lead to an emotional crisis because, without reconstruction, a poorer QOL may result (Johnston, 2012; Caple and Schub, 2014). A Couples interventions and mindfulness practices have been identified as useful ways for both individuals and couples in cancer care to address self-identity and body image (Johnston, 2012). These findings suggested that attention be paid to understanding daily Buddhist practices such as the effect of chanting in the present research.

Paper 5: Cheng *et al.* (2013)

This research studied the role of fatalism in breast cancer survivorship, involving participants from a local self-help organisation in China. A sample of 100 participants completed a cross-sectional survey, of whom 29 were then purposefully selected to take part in in-depth interviews in the second phase of the research. Although the women engaged in a self-help coping management programme, they believed in fatalism and felt they had no ability to change their final outcomes regarding cancer. Cheng *et al*. (2013) found that these Chinese women felt powerless to change their fate because they perceived the occurrence of cancer to be the will of God.

The median length of survivorship in this cohort was 45 months (23–60 months) after the completion of treatment and half of the participants had a religious faith, either Christianity or Buddhism, and were able to communicate in Mandarin. All of them were continuously threatened by the risk of recurrence and, therefore, the fatalistic appraisal was a better way to accept the consequences of cancer. Their perception of 'ming' (the Chinese word for fatalism) is as a supernatural force that determines their life expectancy and is therefore beyond human control. Cheng *et al*. (2013) argued that the notion of 'ming' might be understood as passive and fatalistic; however, it should not be viewed as implying a maladaptive coping adjustment exists amongst the Chinese women. The researchers were aware that, had their study explored different religious affiliations, it would have provided an even clearer picture of the role of fatalism. This also calls attention to the idea that family member support can help breast cancer patients to overcome fatalistic attitudes toward cancer such as talking about their concerns and encouraging them to be strong in their faith as a source of strength (Hamilton *et al*., 2015). Further research focusing on the role of either Christianity or Buddhism in long-term coping processes was therefore suggested, including regarding family members’ perceptions of fate.

Cheng *et al*. (2016) carried out additional research to explore the experiences of long-term changes in a period ranging from six months to 180 months of posttreatment survivorship. This study provided a unique understanding of specific negative and positive changes in the Chinese population that reflect the sociocultural context of their individual experiences. Furthermore, participants experienced a heavy financial burden because of self-financed and substantial medical and health expenditures. Cheng *et al.* (2016) expressed concern about the negative financial impact on long-term survivorship and highlighted the positive nature of Chinese culture in optimising human potential ‘to turn a curse into a blessing’.

Paper 6: Sampoornam (2015)

Sampoornam (2015) interviewed a 55-year old woman with breast cancer and explored her family narratives, as all members of her family practiced Hinduism in India. Whilst Hindus look for a total spiritual awakening, most women in this study practice Hinduism meditation every day and believe that such actions will produce good outcomes (Abu-Raiya and Pargament, 2015). Three themes that emerged included the quantity and quality of relationships, involvement in groups, and maintaining relationships. Believing in God and participating in religious groups acted as a core point that helped the whole family to better cope with the crisis and increased their sense of self-worth and feelings of security. An integrated social support system enhances the sense of belonging and of receiving love and tender care, which encourages women to share their concerns (Al-Azri *et al*., 2009). This study shows the importance of family and social support and thus a home visit was suggested for the interviews in the present research.

Paper 7: Barthakur *et al.* (2016)

This study included in-depth interviews with 15 women with breast cancer in urban India and aimed to explore how to improve the quality of cancer care in an oncology setting. Most survivors rely on their doctor’s choice of treatment in this developing country. In an Indian context, some of the patients' relatives asked the doctor not to inform the patient of the diagnosis on the grounds that ignorance is bliss and then thanked God for such an arrangement. Barthakur *et al*. (2016) argued that a patient-centred style rather than a doctor/disease-centred approach is preferable in terms of influencing physical and mental health outcomes. In India, cultural norms around privacy require that the body not be exposed to other people. Therefore, it is difficult for a male surgeon to examine the breasts of a woman. The difference between rural versus urban patients focused on the belief that faith, more than anything else, cures people; urban patients' experiences did not involve any counselling, which resulted in extreme suffering. There is room in the present study for exploring the experiences of Hong Kong cancer patients living in urban areas.

Paper 8: Chen *et al.* (2016)

Chen *et al.* (2017) investigated the acceptance process of 18 Chinese breast cancer survivors living in Beijing using a ground theory method to conduct individual interviews to collect data. To develop the acceptance theory used, the constant comparative coding analysing method, which has five cognitive reconstruction categories, was employed. It is important to shows the process of acceptance including nonacceptance, passive acceptance, willingness to accept, behavioural acceptance, and transcendence of acceptance. Previous research efforts largely do not provide an in-depth understanding of how acceptance occurs and mainly describe the shift of passive acceptance to compliance to reality.

Active acceptance implies a fighting spirit and shows an active motivation to continue loving their children and maintaining role function normalcy (Chen *et al*., 2017). This is the first qualitative study to provide insight into Chinese women's acceptance as an ongoing process in the B-COPE scale measurement, which previously was used in Iranian and Greek women in a quantitative study (Chen *et al*., 2017). This finding of acceptance is consistent with those of other studies and the strength is the data analysis steps of a clear explanation including opening and axial and selective coding stages. However, the sample size was small (18 patients) and highly selected based on the theoretical sample criteria and data saturation. Furthermore, the sample came from a largely tertiary teaching hospital, which could not reflect the situation of the rural areas and actual phenomenon of poor people in China. There is a common phenomenon of self-blame regarding bringing financial and care burdens onto the family in China. Women are also worried about unemployment leading to a loss of income for supporting the family. The highest stage, transcendence of acceptance, is a spiritual acceptance of a new understanding of life and individual growth. Therefore, this study inspired the use of interview questions to focus on how to develop spiritual well-being and what people think and believe to be fact-acceptance, self-acceptance, and social-acceptance and further how to experience individual growth.

Paper 9: Ahmadi *et al*., (2016)

Ahmadi *et al*., (2016) conducted face-to-face interviews with 33 Korean cancer patients that explored how they coped with various types of cancer within their cultural context. The choice of coping methods spanned existential, spiritual, and religious dimensions (Ahmadi *et al.*, 2016). The themes that emerged were a belief in the healing power of nature, a mind–body connection, a reliance on transcendent power, and finding oneself in relationships with others (Ahmadi *et al.*, 2016). The meaning-making form of coping was a significant aspect of secular spirituality, as Koreans in South Korea largely do not identify themselves as religious (Ahmadi *et al.*, 2016). Their most effective coping resource was a belief in the natural healing power of mountains, which create a healing energy that revitalises all living things (Ahmadi *et al.,* 2016). Almost all the participants in this study believed that natural foods (called Chung-Gook-Chang in Korean) worked as an anticancer medicine, such as the fast-fermented yellow bean paste (Ahmadi *et al.*, 2016). Knobf and Erdos (2018) suggested that nurses should take into account ethnic foods to give more appropriate dietary advice for those who receive chemotherapy.

Participants used their positive-life perspectives to be more appreciative and adopted self-responsibility in their new life per the Korean mantra of ‘do your best, then God will do the rest’, (Ahmadi *et al.*, 2016). This study was useful in providing an attractive illustration of the spirituality and culture divide, for example, a self-responsible attitude toward cancer was adopted, which originated from a Chinese Confucianism mindset (Ahmadi *et al.*, 2016).

Paper 10: Jimenez-Fonsecal *et al.* (2018)

Spirituality is a multidimensional concept that can be interpreted in one way as having fighting spirit, the need to find meaning, and self-fulfilment

(Jimenez-Fonseca, 2018). The effectiveness of spiritual intervention and the effects on psychological adjustment outcomes were uncertain in oncology patients, as such was difficult to measure due to the unique characteristics of the patients involved and their different stages of cancer (Kapler *et al*., 2004; Jimenez-Fonseca, 2018). Moreover, most spiritual care instruments are designed not only for Western populations but also for Protestant and Catholic beliefs (Cockell and McSherry, 2012).

Cockell and McSherry (2012) discovered only 45 articles on spiritual care in nursing published between 1983 and 2005, but were more successful in identifying and then carrying out a systematic review of 80 papers on spiritual care in nursing that were published between 2006 and 2010. They were aware that the nursing profession applies many spiritual care instruments including the Spiritual Care Competencies Scale, the Spirituality and Spiritual Care Rating Scale, the Spiritual Well-being Scale and Spiritual Perspective Scale, and Wolman’s Psycho Matrix Spirituality Inventory (Cockell and McSherry, 2012). In the UK, in 2009 and 2011, the National Secular Society questioned the need for hospital chaplains, as nurses could provide the spiritual care referrals that would fulfil the patient's needs (Cockell and McSherry, 2012). Anandarajah *et al*. (2016) pointed out the major barriers to providing spiritual care as worrying about saying the wrong things during an assessment, being concerned about what to do in therapeutic counselling, and being afraid of conflicts in beliefs. Spiritual well-being may reduce psychological stress and may cultivate improved meaning, purpose, and comfort in life (Garlick *et al.*, 2011). This highlights that the spiritual care study design is better for measuring variables in a single cohort at one time, without demonstrating a causal relationship among variables in different cancer populations (Bovero *et al*., 2016).

In conclusion, the present research's design needs to go beyond self-report scales and incorporate new and innovative ways of measuring religious and spiritual coping among non-Christian samples in adjusting other confounders (Abu-Raiya and Pargament, 2015). There are a lot of confounders that were difficult to control in quantitative research studies such as sociodemographic, health, health behaviour, social support, social activity, and marital status variables. It is likely that other, qualitative studies exist that have explored the intersection between religious coping and health and well-being. There is therefore a knowledge gap, particularly in the medical/health professional literature regarding the understanding of religious beliefs and their influence on spiritual well-being in Chinese breast cancer patients.

2.6 Buddhist Coping

2.6.1 Research on Buddhist Coping

Numerous studies have examined religious coping, and the Religious Coping Scale (RCOPE) has been used previously to measure the outcomes for Christian, Jews, Hindus, and Muslims (Phillips *et al*., 2012). Phillips *et al*. (2012) developed an initial validation of the Buddhist Coping Scale by recruiting 860 participants in the US. The Buddhist Coping Scale's variables include impermanence, mindfulness, compassion, and karma to search for meaning in life. Overall, the questionnaire included 14 types of Buddhist coping and 17 subscales relating to different Buddhist beliefs. Phillips *et al.* (2012) then developed the Buddhist coping measure based on the subscales' correlations with measures such as general desirable outcomes, learning from stressful situations, satisfaction with life, depression, anxiety, and anger. They also pointed out that recent research on Buddhist coping consisted of three categories: the first line of qualitative research was with Eastern Buddhists, the second line examined Buddhist mindfulness practices in non-Buddhist Western peoples, and the third line of research involved the correlation and construction of Buddhist concepts (Phillips *et al*., 2012).

Positive Buddhist coping methods included (1) intentional morality, (2) meditation, (3) Sangha support, (4) active but meaningful karma, (5) impermanence, (6) not-self, (7) right understanding, and (8) mindfulness (Phillips *et al*., 2012; Abu-Raiya and Pargament, 2015). Negative Buddhist coping methods included (1) fatalistic karma, (2) bad Buddhist and (3) not easy being Buddhist (Phillips *et al*., 2012; Abu-Raiya and Pargament, 2015). Falb and Pargament (2013) used the Buddhist coping measure to determine the effectiveness of mindfulness-based therapies; its use is firmly established and has provided evidence-based support for acceptance and commitment therapy, and also mindfulness-based cognitive therapy in quantitative research. However, there is no instrument in existence that measures how participants use Buddhist ideas and practices in response to a stressful life event at this time (Phillips *et al*., 2012).

Falb and Pargament (2013) further explored the relationship between Buddhist coping and end-of-life caregivers' psychological functioning. Ninety-two caregivers were recruited to enrol in training programmes given by a Buddhist chaplain, and the primary measure included the Buddhist coping scale, which incorporated spiritual well-being, burnout, depression, and posttraumatic growth. As hypothesised, a greater use of positive Buddhist coping methods resulted in lower levels of negative outcomes and higher levels of positive outcomes being achieved (Falb and Pargament, 2013). Moreover, the results showed there to be positive Buddhist coping for unique outcome variables including personal accomplishment, meaning and peace, and faith. The negative outcomes that arose were emotional exhaustion and depersonalisation (Falb and Pargament, 2013). How does Buddhism promote helping people to stay healthy? This body of research is limited in its scope in that it focuses almost exclusively on non-Asian-Americans. Future studies will need to explore Buddhist religious coping methods in larger and more diverse Buddhist samples (Phillips *et al*., 2012; Abu-Raiya and Pargament, 2015). What, however, is the coping theory in Buddhism?

2.6.2 A Buddhist Coping Theory

Buddhism can play a significant role in people's responses to and interpretations of illness in a different way. The Shakyamuni teaching of the Lotus Sutra introduces the '3,000 realms in a single moment of life (Ichinen Sanzen)' principle so that we can establish our innate Buddhahood. The 'Ichinen Sanzen' subprinciples include 'the oneness of body and mind' and 'the oneness of life and environment' (Ikeda, 2003). Buddhism considers itself to be a 'system science' concerned with understanding the totality of all life's phenomena. Furthermore, the Buddhist term *shiki shin funi* means the 'oneness of body and mind', which states that the 'body and mind are not two but two'; thus there is an interaction between body and mind (Ikeda, 2003). For example, emotional stress gives rise to physical responses such as changes in blood pressure, blood glucose level, and muscular tensions. There is an increasing understanding of the reciprocal influence of mind and body. Xu (2012), for example, explored how elderly Chinese Buddhists in Singapore perceive their life stress and developed a conceptualisation of Buddhism-as-a-meaning system (BMS) and a BMS-based model. A Buddhist approach consists of nine dimensions including (1) karma-based coping, (2) wisdom-based coping, (3) emotion-based coping, (4) meditation-based coping, (5) compassion-based coping, (6) existential coping, (7) multiple coping with health-related stress, (8) religious struggles, and (9) stress-related growth (Xu, 2012). There have been few qualitative investigations that have explored other types of Buddhist meditation.

According to Thailand culture, the Buddhist beliefs and practices provide the moral support that helps breast cancer survivors to enhance their healthy emotional well-being by merit-making. Sirisupluxana *et al*. (2009), drawing on Heideggerian phenomenology, conducted interviews with 17 Thai women who had survived breast cancer to explore the meaning of complementary therapy. Six themes were generated, as follows: cancer-controlling treatment, mental strengthening, mind and body therapy, self-determination, natural therapy, and conventional therapy integration (Sirisupluxana *et al*., 2009). Suwankhong and Liamputtong (2016) then conducted in-depth interviews with 20 breast cancer women who lived in rural communities in southern Thailand; many of these women received most of their social support from their family members and relatives. Suwankhong and Liamputtong argued that health care providers largely provided insufficient social support, which reduced the capacity of women with breast cancer to manage their illness, thus impacting their well-being. Furthermore, Buddhist meditation practice was another means of spiritual support used to relieve the side effects of treatment and achieve a more peaceful life.

2.6.3 Mindfulness-based Stress Reduction Coping Experiences

Kabat-Zinn (1990) researched the MBSR programme in US, which was an outpatient program administering behavioural medicine for patients with chronic pain. It mainly focused on meditation effects concerning the body and mind's reactions to facing stress, pain, and illness (Kabat-Zinn, 1990; Edenfield and Saeed, 2012). MBSR was based on intensive training in mindfulness meditation and focused on continually changing internal states and on developing the ability to cultivate moment-to-moment awareness by practicing mindfulness skills for chronic pain and stress-related patients (Bear, 2014). When people have suffered from anxiety and depression, thinking negatively can become habitual. Mindfulness invites people to be open and accepting of all experiences in their own way using a nonjudgmental, patient, and kindly attitude which is an intentional mode of mind (Edenfield and Saeed, 2012; Kuyken and Evans, 2014).

Recently, the Buddhist philosophy developed mindfulness-based interventions (MBIs) for cancer care that are particularly helpful in dealing with common experiences related to cancer stress in the context of symptoms including depression, insomnia, and fatigue (Carlson, 2018). In stressful times, Buddhists focus on achieving a correct understanding and mindfulness. Casellas-Grau *et* *al*. (2014) carried out a systematic review of positive psychological interventions in breast cancer patients, evaluating 7,266 articles and incorporating 16 studies with sample sizes ranging from 14 patients to 194 patients. Five forms of group therapy were identified including mindfulness-based approaches, the expression of positive emotions, spiritual interventions, hope therapy, and meaning-making interventions, all of which can cultivate positive feelings, well-being, and personal strength. Furthermore, the MBSR programme was the most commonly used therapy in breast cancer patients in terms of enhancing the ability to be aware of the present moment and for feeling calm and confident. These further developed to include supportive–expressive therapy in distressed breast cancer survivors and an online adaptation of a mindfulness-based cancer recovery (MBCR) programme to help remote patients cope with cancer (Carlson *et al*., 2015; Carlson, 2016). One funded study evaluated the effect of the MBCR program on biomarkers, including cytokine production, telomere length, salivary cortisol, and gene expression, in different types of cancer survivors in Calgary and Toronto from 2016 to 2021 (Carlson, 2016). Other studies utilising meaning-making interventions reported that participants felt increased self-esteem, self-efficacy, and optimism, even during the chemotherapy period, and provided written expressions of enhanced hope, even in the three-month follow-up period (Casellas-Grau *et al*., 2014). Another hope intervention increased confidence immediately, though such could not be maintained at the three-month and 12-month follow-ups.

The practice of mindfulness meditation can change people’s habitual beliefs and perspectives by focusing their breathing, in and out, to change their mind, thoughts, bodily sensations, and feelings (Kuyken and Evans, 2014; Bear, 2014).

Hoffman *et al.* (2012) conducted a large randomised controlled evaluative trial involving 92 participants with stages 0 to III breast cancer who had completed eight weeks of a MBSR program conducted at the Haven, an integrated cancer support centre in London, UK. The most positive experiences reported by participants (n = 92) were feeling calmer, centred, at peace, connected, and more confident and mindful (Hoffman *et al.*, 2012). Survival rates for breast cancer increased and the community thus accepted that breast cancer was a long-term illness leading to a greater emphasis on rehabilitation and subsequently the QOL of these women (Jassim *et al*., 2015). It was because mindfulness focuses on 'bare awareness' to overcome emotional distress and emphasizes loving-kindness towards the self and others. A more positive attitude, proactive behaviour, and religious coping were positively associated with long-term posttraumatic growth (Garlick *et al*., 2011). There are few studies in existence that evaluate the effects of MBIs and MBCR programmes in Hong Kong. Thus, the present qualitative study sought to address the gap as a pioneer to explore the Buddhist practice of chanting and meditation in cancer coping.

2.7 Cancer Care and Experience: Hong Kong Context

There exists an enormous public health challenge given the increasing number of new cancer cases being diagnosed in Hong Kong (31,468 in 2016; median age at diagnosis was 56 years) (Hong Kong Cancer Registry, 2018). In 2016, there was a 5.3% increase in the number of invasive breast cancers in women increased (4,100), while 599 cases of in-situ breast cancer were identified (Hong Kong Cancer Registry, 2018). The triple test involves carrying out a fine-needle aspiration biopsy for evidence of pathology, mammography imaging and ultrasound findings, and clinical breast examination (Vargas *et al*., 2003). A cytopathology or histopathology report is also required for a definitive diagnosis of breast cancer (HA Guideline on Management of Breast Cancer, 2009). Most breast cancers were diagnosed from the presentation of a palpable breast lump, and 81.8% of women had invasive ductal carcinomas (Kwong *et al*., 2011). In 2014, 98.3% of 12,023 breast cancer patients had undergone surgery, including 63.1% who had undergone a mastectomy and 35.1% who had undergone breast-conserving surgery (Hong Kong Breast Cancer Registry, 2014).

It is important to understand the genetic implications, as this may have an impact on how women view their reasons for developing breast cancer. Poor prognosis indicates both HER-2/neu (Human epidermal growth factor receptor 2) and an EGFR (Epidermal growth factor receptor) are present and found in both node-negative and node-positive breast cancer (Tranin, 1996; Campeau *et al*., 2008; Yang *et al*., 2015). Kwong *et al*. (2014) reported that male breast cancer is relatively rare and identified 132 male and 8,118 female breast cancer patients registered in Hong Kong’s medical records from 1997 to 2006.

Gadamer (1975) asserts that we belong to history and our traditions, and, for Hong Kong, there exists a complex relationship with mainland China. The Qing Dynasty and the British Government signed the Treaty of Nanking on 29 August 1842, after which Hong Kong Island became a British colony (Tung Wah Group of Hospitals Records and Heritage Office, 2010). The first Civil Government Hospital was run by foreign staff facing language and cultural barriers and the cost of hospitalisation was also unaffordable for the Chinese, as there was a charge of HK$1 per day (Leong, 2008). It has been argued that Chinese ethnicity and cultural norms are based on mutual respect and prevent recipients from experiencing a ‘loss of face’ when seeking treatment (Chan and Palley, 2005). Leong (2008) argued that the Chinese exhibit anti-hospital feelings because of the cultural and political obstacles involved. Traditional Chinese values are based on the Buddhist and Confucian virtues of enduring suffering to maintain harmony (Chan and Palley, 2005; Law, 2016). The Chinese have initiated many charity events and organisations to develop mutual helping attitudes and a philanthropic atmosphere such as the Hong Kong Cancer Fund and the Hong Kong Breast Cancer Foundation. Even recently, cancer patients still continue to perceive Chinese medicine as part of their tradition and believe it could help them to sustain health and longevity. The Tung Wah Group and the Tai Shan Charity Association (TSCA) provide free traditional Chinese medicine consultations to cancer patients.

The risk of breast cancer for Asians born in the West has increased six-fold as compared with in those born in the East (Kwong *et al*., 2011). From a historical perspective, Hong Kong has a complex and multifaceted combination of traditional Chinese culture and a way of thinking influenced by the Western approach (Chan and Palley, 2005). More than 70% of the parents of women with breast cancer come from the Southern Mainland of China and thus originate from Guangdong province; their lifestyles are therefore more Westernised due to Hong Kong’s unique history of being a British colony for 99 years (Kwong *et al*., 2011). According to the Hong Kong Hereditary Breast Cancer Registry, 84% of women with breast cancer were born in Hong Kong (Kwong *et al*., 2011). Hong Kong has increased its numbers of Chinese migrants through marriage since

1997; this is likely to change the pattern of breast cancer because migrants come from a different socioeconomic context and lifestyle (Kwong *et al*., 2011).

Without exploring in greater depth the underlying conflict and nature of social identity, it is difficult to understand the motivational roots of an individual's behaviour (Phua and Rowlinson, 2004). Understanding tradition requires that historical consciousness be transposed onto historical horizons (Gadamer, 1994). In 1997 mainland China exercised sovereignty over the entire territory, which meant that Hong Kong became a Special Administrative Region of China and has experienced dramatic changes over the years (Kennedy, 1994). China has adopted a 'one country, two systems' approach toward Hong Kong, which is expected to accelerate China's revolutionary efforts to modernise its economy (Kennedy, 1994). Kennett and Mizuuchi (2010) have pointed out that Hong Kong became one of the most dynamic economies in the world following its transformation to 'market socialism' in the 1980s; this preceded a rise in the Gross Domestic Product (GDP) from 73% in 1988 to 86% in 1998, and then to 92% in 2008. However, the Asian Financial Crisis in 1997 and the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003 both contributed to a severe economic downturn (Kennett and Mizuuchi, 2010). The subsequent structural and social changes created many stressful life events in Hong Kong, including housing insecurity, poverty, social exclusion, and inequality (Kennett and Mizuuchi, 2010). Researchers who consider Chinese culture seldom to talk about the political issues in public, so most interview questions would not actively ask about the political dimension of being-in-the-world.

Spiritual well-being is affected by uncertainty about the future and by searching for the meaning of life (Alfano *et al*., 2018). Women's experiences are different from those of men in terms of their sexuality, identity, and demands regarding femininity (Laranjeira *et al*., 2013). How do female cancer survivors therefore experience their lifeworld after cancer? From a phenomenological and feminist perspective, cancer survivorship is an existential issue that addresses needs pertaining to the transition of self-identity and spiritual well-being (Laranjeira *et al*., 2013). Hong Kong embraces diverse religious beliefs and faiths; however, nursing education and care seldom address religion. Hong Kong nurses found it difficult to provide spiritual care due to an increased workload; lack of time; feelings of inadequacy in delivering spiritual care; and a lack of education, knowledge, and skills (Wong and Yau, 2010). There are few qualitative studies that have explored how women experience 'becoming and being' breast cancer survivors with Buddhist faith and about how they constructed their spiritual well-being. This study would translate the knowledge gained on spiritual care and coping mechanisms into clinical practice.

2.8 Summary of Coping Experiences Related to the Hong Kong Context

Coping is viewed as a process that is multidimensional, multilayered, and contextual (Lazarus and Folkman, 1984; Rice, 2012; Ahmandi *et al*., 2016). Firstly, it includes sociocultural and contextual influences on coping strategies (Yoo *et al*., 2014). Hong Kong has a special history as a British colony and of Chinese tradition and culture, which might have an influence on women's coping experiences. Hong Kong people have suffered a financial crisis and social changes since 1997, thus leading to many stressful life events in Hong Kong including housing insecurity and poverty (Kennett and Mizuuchi, 2010). Cancer may be a long-term process that is manifested in different life domains, including physical health, psychological impact of self-image, and social financial burden. Secondly, coping styles differ according to demographic and educational characteristics; a holistic approach to care is needed including regarding mental and psychological well-being, social support, and the use of religious faith and practices (Teal *et al*., 2018). Hong Kong people embrace other people with different faiths including Catholicism, Protestant, Islam, Confucianism, Daoism, and Buddhism. Many people across diverse religions have relied on their religious teachings to cope with life's challenges. For example, in the case of Christians, studies have indicated people report using positive religious coping methods far more frequently, including prayer and church attendance, to ensure positive physical and mental health outcomes (Abu-Raiya and Pargament, 2014). Thirdly, more active people were proactive in terms of problem-solving or optimistic when overcoming a fatalistic attitude with their cancer diagnosis (Hamilton *et al*., 2015). One major limitation is that much of the current religious coping research has focused on Christian and Islam samples and, therefore, the findings cannot be generalized to individuals of other faiths (Abu-Raiya and Pargament, 2014). Finally, the most frequent coping responses involve the use of religious faith and practices to accept and adjust in their lives, as they are proactive, goal-directed beings who search for their life meaning (Hamilton *et al*., 2015; Kato, 2016).

In this second section, I conclude the synthesis of the literature review by considering three themes, which are:

Theme 1: ***Stress and Coping Response***

Theme 2: ***Transition Pattern of Self-Identity***

Theme 3: ***Spiritual Coping***

I will explore the above three themes in the interpretation of findings in the chapter of discussion later.

2.9 Chapter Summary

In this chapter, the literature review outlined the concept of cancer survivorship and faith. The critical issue was regarding how to live well with cancer. This small-scale qualitative study will be situated in Hong Kong. The Lazarus and Folkman coping model was employed to discuss three aspects of having breast cancer. The literature review provides the insight to build up the methodology of this study. This Buddhist coping review highlighted the limited knowledge about MBIs in Hong Kong, for example, regarding the coping of Chinese breast cancer survivors. This study could therefore provide information that would fill this knowledge gap and contribute to providing insights on the Buddhist coping theory. The following chapter presents how the methodological rationale and the reflexivity shaped the research enquiry.

Chapter 3: Methodology

3.0 Methodological Rationale

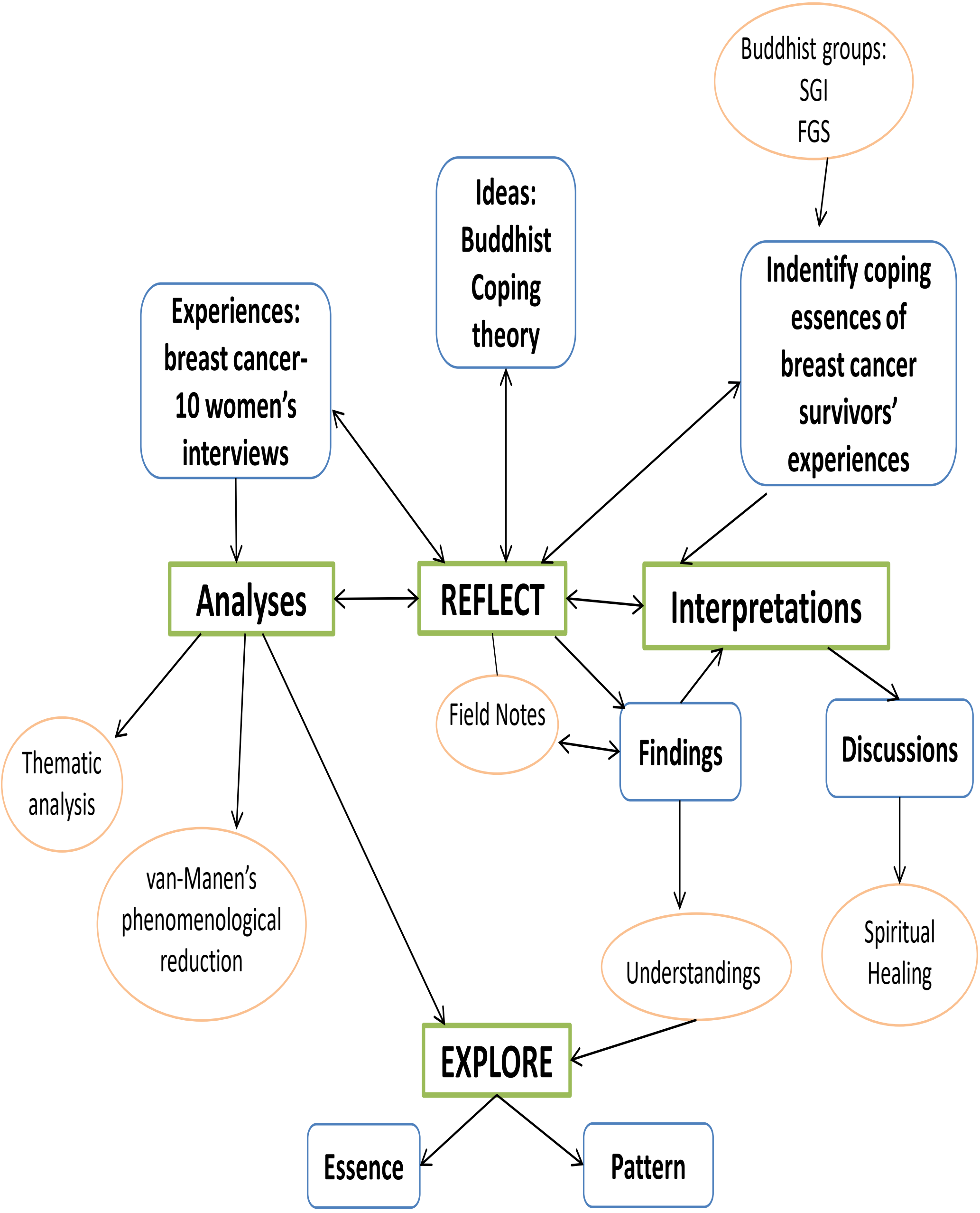
The quality and effectiveness of cancer care can be measured using a qualitative and/or quantitative paradigm, depending on the research questions, aims, and objectives. A qualitative research focuses on exploring the meanings people ascribe to their everyday lives; it is concerned with the views and perspectives of people and explains human social behaviours using multiple sources of evidence (Punch, 1998; Creswell, 2003; Silverman, 2010; Offredy and Vickers, 2010; Yin, 2011). The Greek word *phaenesthai* (phenomenon) means 'to show itself' and is constructed from *phaino,* which means 'to place in brightness' (Moustaks, 1994). Phenomena are a description of the essence of things including the appearances of things, things as they appear in our experience, and the way we experience things (Husserl, 1925). Husserl's intentional analysis included both intention itself (*noesis*) and the intention object (*noema*) as well as an understanding of the consciousness regarding what is experienced (*noema*) and the way it is experienced (*noesis*) (Ihde, 1977; Jin, 2004; Langdridge 2007). A phenomenological paradigm can be descriptive and interpretive: therefore, phenomena are studied through the eyes of people from within their lived situations (Rubin and Rubin, 2012). A phenomenological approach would thus be more appropriate for the current study, as there is no requirement for a data saturation process and phenomenological research pays more attention to individuals and their unique lived experiences.

3.1 Reflexivity in Research Design

3.1.1 My Own Preconception

Since they were in line with many qualitative research traditions, I did not carry out a comprehensive literature review of breast cancer research prior to beginning my research interviews; rather, an iterative flow was developed between data collection, analysis, and reflection on the literature. At the inception stages of the project, I was unfamiliar with much of the phenomenological research and methodology, which initially felt challenging. Bracketing is similar to the Buddhist concept of 'no selfness'. Descartes (1968) highlighted the special meaning of ‘I’, which was enshrined in ‘I think, therefore I exist’ (*Je pense, do je suis*) (van Manen, 2014, p. 77). Here, the self is thinking of its own existence and what is needed to understand the soul or mind. Our consciousness is intentional in that it is always pointed toward something; thus we can be conscious of our own body, emotions, thoughts, and desires in an existential perspective (Benner, 1994; Moustakas, 1994; Hein and Austin, 2001; Lui, 2004,). Studying consciousness experiences evokes similarities to the concept of Ichinen Sanzen (p.xix) in Buddhist theory. My own preconceptions made me believe that suffering was an illusion of the ‘self’ meaning-making process in my mind. Heidegger's and Gadamer's idea show that all understanding is part of the self-understanding process. The researcher understands human experiences through their cultural world, historical tradition, and the context that connects their language or dialogue (Welch,1999; Grondin, 2003). In this regard, I developed a mind map before data collection.

Mind Map



Buddhist groups:
SGI
FGS
Ideas: Buddhist Coping theory
Experiences: breast cancer- 10 women's interviews
Indentify coping essences of breast cancer survivors' experiences
Analyses
REFLECT
Interpretations
Field Notes
Findings
Discussions
Thematic analysis
van-Manen's phenomenological reduction
Understandings
Spiritual Healing
EXPLORE
Essence
Pattern

3.1.2 My Key Decision

I had initially struggled to distinguish the descriptive or interpretative phenomenological approaches. A key question was whether to ‘bracket’ my personal perceptions. I did not put aside my personal Buddhist values and experiences. Hermeneutics was thus an attempt to interpret and make sense of certain phenomena through inferences that are made regarding hidden and disclosed meanings (Parse, 2001). Hermeneutic phenomenology was selected as a suitable methodology for the current research.

3.1.3 My Interactions with Participants

The phenomenon of individual experiences in a natural setting is a central methodological focus for this current study. A natural setting involves studying things as they are and refraining from manipulating the environment to represent a real-life situation (Creswell, 2003; Offredy and Vickers, 2010). I decided to introduce my Buddhist disciple identity at the very beginning of each interview and wanted to fully adopt a reflexive approach to the interview process. The participants were asked to describe their lived experiences as they perceive them (Nieswiadomy, 1993). Everyone's personal experiences were ‘lived through’ and their senses enacted with reflections that awoke and guided our direction of interest (Heidegger, 1962). All10 participants and the researcher built trust and rapport in their first encounters; the participants were willing to talk in an open manner because they hoped to share their experiences and thereby encourage other breast cancer survivors.

3.1.4 My Lived Experiences

My lived experiences are both as a patient and a researcher, which provided an insight to understanding the fear of sudden death. I had abnormal mammogram results in July 2018. My mind went as far as planning for the operation, planning for my family and work, and becoming anxious due to this kind of uncertainty. We can choose to appreciate or complain about something depending on whether we are in a glass half-full or glass half-empty kind of mood. Buddhism is a philosophy of action that I chose in order to kickstart habits that initiate hope. After chanting the Nam-myoho-renge-kyo, I accepted whatever the outcome may be. My belief was the Gohonzon that let me have a normal result. Still, I was more sensitive to their situation than I otherwise would be. Consequently, I understood participants' feelings through this view with insider empathy rather than outsider sympathy.

3.2 Heidegger's Interpretive Phenomenology

A phenomenological approach is concerned with exploring how people view, engage with, and make sense of the world from within a unique historical and social perspective that is shaped by their culture (Creswell, 2003; Hein and Austin, 2001). As Heidegger alludes:

> *‘Space is neither in the subject, nor is the world in space. Rather, space is "in" the world since the being-in-the-world constitutive for Dasein has disclosed space. Space is not in the subject, nor does that subjective observe the world "as if" it were in space’* (Heidegger, 2010, p.108).

In this current study, the phenomenon of interest is the impact that Buddhist beliefs have on women surviving breast cancer. To expand the scope of knowledge regarding their coping processes, it was appropriate to use interpretive and hermeneutic phenomenology to explore the meaning of their experiences. The existential investigation is illustrated as follows:

Box 1: The Phenomenon: Existential Investigation

The Phenomenon: Existential Investigation

↓

Data Collection

Personal Experiences	Researcher Reflection
10 participants in Hong Kong	Recorded in personal journal
20 face-to-face individual interviews	

↓

Data Analysis

Thematic Analysis	van Manen Data Reduction
Being	The Lived Space
Being with others	The Lived Body
Being in the worlds	The Lived Time
	The Lived Human Relation

Data Interpretation

↓

The Gadamer Hermeneutic Interpretation: A Fusion of Horizons

↓

Findings

Heidegger's interpretive phenomenological approach focused on ‘being’ (Dasein), being-with-others, and being-in-the-lifeworld (Lebenswelt), which he associated with care, anxiety, and the uniqueness of the person living in the world (Heidegger, 1962; Welch, 1999). Being thus finds its meaning in their lifeworld, which constitutes the sociality, spatiality and temporality that is termed their 'world-history' (world-historical historicising) (Heidegger, 1999). Heidegger therefore claims that the world is a priori and given in the practices, language, and culture developed in our history (Leonard, 1994). Heidegger was concerned with the ‘truthfulness of a worthwhile [*wertvolle*] and self-cultivated [*sich aufbauenden*] life’; thus, the genuineness of human life could speak louder than theory (Crowe, 2006). Heidegger offered an analysis of human existence or Dasein (“being there”) that included the problem of Being—that is, ‘the interpretation of Being’, which motivates self-understanding in both Being and Time (Heidegger, 1988). Heidegger believed that the very nature of our being in-the-world is shaped by what we ‘care’ about and pay attention to in our lifeworld (Khatri *et al*., 2012). The Heideggerian notion of 'care’ structure means being drawn towards things in your world that are of personal concern and which incorporate ‘facticity, fallenness and existentiality’ (Heidegger, 1962). For example, Blinderman and Cherny (2005) explored existential being in the palliative care setting. ‘Being-there’ is equivalent to ‘Being-in’, which means being able to manage and be competent enough to do something (Heidegger, 1988). Meaningful lived experience (*Erfahrungen*) can transform the person's wisdom and eventually affects their being and belonging (van Manen, 2014).

3.3 The Historical Meaning of Hermeneutics

The Greek word *hermeneuin* means interpretive and is derived from the name of the Greek god Hermes, who interpreted messages sent from the gods to the people (Parse, 2001). Hermeneutics is a method used in religion to interpret biblical text, poetry, and other literary works (Parse, 2001). Schleiermacher (1805–1977) described hermeneutics as the inquiry method of the human sciences and his student, Wilhelm Dilthey (1883–1988), wrote of the importance of the hermeneutic circle in interpreting from words and sentences in order to gain an understanding reflective of a whole life (Parse, 2001). Schleiermacher viewed hermeneutics as the 'art of understanding' and he did not make a clear distinction between understanding and interpretation (*Auslegung*) (Mueller-Vollmer, 1988). Heidegger's writing shifted hermeneutics towards the understanding of human existence (Heidegger, 1999). Hermeneutics, for Heidegger, refers to the process of interpreting written texts and other cultural objects such as art (Hein and Austin, 2001). There are many differences of understanding and interpretation regarding the conditions of the body, mind, and of the different historical and social backgrounds relating to each whole person (Chladenius, 1988). No two individuals can have 'one and the same' perception of things (Chladenius, 1988). Understanding is therefore not a cognitive act pertaining to the other person's lived experience but rather the moment when 'life understands itself' (van Manen, 1990). Understanding the 'Being' of such factual potentiality-of-Being is important to know what is capable of possibilities within our world (Heidegger, 1988).

3.4 Gadamer's Historicity of Understanding

Gadamer, a follower of Heidegger, focused not only on existential dimensions but also on hermeneutic dimensions (Finlay, 2006). Gadamer discussed the historicity of understanding in his book *Truth and Method*, which deals with the positive and constitutive character of prejudice in our culture (Gadamer, 1975). Gadamer (1976) separately expanded the hermeneutic turn to incorporate what it means to be human. Gadamer's view of hermeneutics as a practical philosophy suggests that human self-understanding represents both our historical being and our traditions (Dobrosavljev, 2002). The hermeneutic phenomenological method therefore implies that how we perceive our experience is the driving force of human consciousness (Cohen *et al*., 2000). Historical consciousness is aware of its historical horizon, understanding things on the past, present, and future as a continuing tradition (Gadamer, 1988). In fact, the historical horizon merges our traditions and the researcher presents a naïve attitude. It allows the researcher/interpreter to be naïve or suggests that naïvete is always present. Returning back to the things themselves indicates something of the experience between the text and the living value (Gadamer, 1988; Grondin, 2003).

Gadamer (1994) introduced the notion of a fusion of horizon, which is the vision arising from the interpreter's unique perspective of understanding regarding the meaning of being human. Humboldt characterises Heidegger's and Gadamer's historical preunderstanding as a fusion of two horizons, the interpreter ('subject') and the phenomenon ('object'), which share a common and effective historical coherence (Mueller-Vollmer, 1988). The concept of horizon refers to the range of vision from a specific vantage point, thus alluding to individual differences (Gadamer, 2006). Understanding therefore comes from the process of a fusion of horizons (Hein and Austin, 2001). Gadamer argued that language is both the horizon of hermeneutic ontology and the medium of understanding (Gadamer, 1976; Parse, 2001). Language as a process is a means of transporting ‘meanings’ from the mind of one person into that of another (Mueller-Vollmer, 1988). For instance, our language is a medium for communication where similar wordings in a dialogue/text might give rise to different understandings and interpretations by different readers from diverse cultural and historical backgrounds. Furthermore, the hermeneutic mode is dialogical and may include any texts, words, sentences and symbols, art forms, drawings, movement, or other media used to construct meanings (Parse, 2001). Hermeneutics focuses on understanding texts and addresses human experiences as though it has a semantic and textual structure (Gadamer, 1975; Hein and Austin, 2001). Understanding is always an interpretation; we cannot separate ourselves from the meaning of a text (van Manen, 1990). The courage of the interpreter's understanding comes from both their enlightenment and prejudices, which form part of the historical continuum through which he/she shares in the tradition of the phenomenon (Gadamer, 1988). Researchers using hermeneutic phenomenology add the interpretive and reflective elements that construct the participants’ meanings and experiences in their lived worlds (Ajjawi and Higgs, 2007).

3.5 The Hermeneutic Circle

Heidegger refers to the ‘circle’ in understanding as a conscious, rational, and deliberate process applied to the participant's life, including being, being-with-others, and being-in-the-world (Heidegger, 1962; Heidegger, 1988). The hermeneutic circle is thus a ‘notable related backward or forward’ process of interpreting participant quotes and stories (Heidegger, 1962). The first hermeneutic arc focuses on an interpretation of an experience in relation to the question of ‘Being’ (Heidegger, 1962; Heidegger, 1988). The second hermeneutic arc focuses on an interpretation of the question of temporality or ‘Time’ (Heidegger, 1962; Heidegger, 1988).

> *‘The “circle” in understanding belongs to the structure of meaning, and the latter phenomenon is rooted in the existential constitution of Dasein—that is, in the understanding which interprets. An entity for which, as Being-in-the-world, its Being is itself an issue, has, ontologically, a circular structure’ (Heidegger, 1962, p.195).*

Gadamer (1975) further developed the concept of hermeneutic circle (*hermeneutischer zirkel*) which is the process of understanding a text whre the meaning of a text is constructed within its cultural, historical, and literary contexts. The process is thus circular rather than linear (Gadamer, 1994; Streubert and Carpenter, 2007). The role of prejudices refers to how we understand influences on the way we experience things from the range of vision, and the fusion of horizon (*Horizontverschmelzung)* linking to our understanding is the fusion of our past and present horizon (Gadamer, 1975; Gadamer, 1976). The data sources include participants’ oral or written descriptions of their experiences of the phenomenon, the researcher's self-reflection on these experiences, and other accounts of the phenomenon (Hein and Austin, 2001). The hermeneutic circle provides an appropriate interpretation and a more in-depth understanding of meaning.

van Manen (1990) suggested the hermeneutic circle also includes readers who interpret the texts of the whole and of the parts, continuing the process of thought as to what is the meaning in and through the words. A full understanding of a phenomenon may, however, not be possible because the questioning does not end with the researcher’s interpretation. There is no true hermeneutic circle; rather, there is a demand for coherence, which can be no saturation point (Grondin, 2003; Finlay, 2006). Although the hermeneutical intuition and interpretive process is not clearly defined, the researcher strives to discover any new essence about the phenomenon. Hermeneutic researchers envision the whole reality on 'existential dimensions', which explore an individual experience as the parts focus on a person's sense of lived space, body, time, and human relation (van Manen, 1990).

3.6 The Hermeneutic Interpretation of Meaning: Step- by- Step

The ‘hermeneutical intuition’ was therefore a process of understanding the back-and-forth formation of concepts from which arose all transcendental experiences and theoretical objectifications (Heidegger, 1962; Heidegger, 1988; Crowe, 2006). The analysis focuses on the participants’ genuine lifeworlds, including their historical and religious lives (Grondin, 2003; Crowe, 2006). It ensures that the specific determination of sense is attended to in everything, rather than only the natural consciousness of the subject matter (Crowe, 2006). Heidegger hermeneutics is the existence of a dimension to understand one's self in modelling on the being of the future, and Gadamer hermeneutics is the existence of the textual dimension for understanding the meanings about the things and the historical being of the past (Heidegger, 1962; Gadamer, 1994; Grondin, 2003).

As a first step, we need to identify and acknowledge the preconceptions that are at work 'everywhere' in the day-to-day experience of life. Our preunderstanding would provide direction in future thoughts and actions (Gadamer, 1975; Gadamer, 1976; Crowe, 2006). The researcher cannot bracket and place aside their prejudices and their perspectives, as these are embedded in their own personal culture and history (Gadamer, 1975; Gadamer, 1976). Furthermore, the researcher needs to acknowledge their own belief systems and render them explicit. Understanding then constitutes a fusion of horizons that describes the range of vision from a specific vantage point (Gadamer, 1975). Secondly, the phenomenologist needs to listen to and feel the experience (Munhall, 1994). Third, the researcher needs to be unknowing, in that they might become one with the experience and raise their consciousness, feel amazed, and even puzzled (Munhall, 1994). Fourth, understanding the world through an individual's perception means that meaning is hidden within the appearance of the phenomenon and may have differences that begin to be understood as 'real' (Munhall, 1994). Last, but not least, there will be open, circular, reflective, or spontaneous moments that exist side-by-side. Therefore, the fusion of horizon method is based on how researchers and subjects interpret the world and the meaning attributed towards Buddhist coping on their cancer journey, and it then attempts to merge these horizons of meaning.

The first step involves a continuous back-and-forth process between the parts of the text and the whole, which begins from an often vague and intuitive understanding of the whole text (Brinkmann and Kvale, 2015). A thematic map is then drawn after organising themes in terms of their similarity. The second step includes an interpretation of meaning of different parts of the text, and these parts are then related to the totality, and so on. Ryan and Bernard (2003) suggested that mental maps are visual displays of the similarities among items and themes that divide data according to the cognitive similarity or dissimilarity between sets of objects. Three kinds of memos were used in this research: code notes, theory notes, and operational notes (Ryan and Bernard, 2003). The third step involves the testing of part interpretations against the global meaning of the text and possibly also against other texts by the same author. For example, the code of the Kosen-rufu (p.xix) has a special meaning for the participants. The spirit of Kosen-rufu requires all disciples and lay supporters of Nichiren to widely declare the Ichinen Sanzen (p.xix) in mutual possession of the 10 worlds (p.xx) of human revolution (p.xviii) and establish the humanistic ideals of Nichiren Buddhism in society. The fourth step concerns the autonomy of the text; the text needs to be understood in terms of its own frame of reference by explicating what the text itself has stated about a theme (Brinkmann and Kvale, 2015). Every interviewee applies their own meaning or understanding to the spirit of Kosen-rufu and, therefore, engages in individual and unique behaviours. The aim is thus to identify concepts and link themes by exploiting clues in the discourse that connect what people have in mind to the things they say they do (Ryan and Bernard, 2003). The repetition of associative linkages thus indicates the pattern of their behaviour. For example, all six participants from the Hong Kong Soka Gakkai International (SGI) mentioned the spirit of Kosen-rufu. Indeed, it was striking how frequently people travel through the same network of ideas in the same Buddhist organization. For example, three participants of Fo Guang Shan FGS shared similar ideas derived from their Master Hsing Yun’s teachings. Furthermore, I also considered what they did not say in order to identify underlying religious and cultural assumptions. I therefore identified themes, describing and comparing them, case by case. However, I was not able to ‘jump outside’ of the tradition of understanding I inhabited and thus understand the phenomena as an insider (Brinkmann and Kvale, 2015). I therefore applied my understanding according to my Buddhist faith and practices. Finally, themes and subcategories were combined into van Manen models that explain the essence of the phenomenon. Every interpretation involves innovation and creativity (Brinkmann and Kvale, 2015). As a phenomenologically intuitive analysis, I felt that the respondents were disclosing their most important mood-dwelling (p.xx) aspects in order to search for the purpose and meaning of life. That the experience has clearly motivated them comes through in their openness to change their negative feelings.

3.7 Challenges in Translation in the Research Process

The challenges of multilingual languages are inherent in the translation and interpretation encountered in qualitative research and suggest one's first language in the data collection, data analysis, and final report (Baumgartner, 2012; Helmich *et al*., 2017; Oxley *et al*., 2017). In order to maintain research credibility, I will describe the methodological challenges in doing phenomenological research across culture and language. All understanding is through 'language' (*Sprachlichkeit*) (p.xx), and the 'translation' (p.xxiii) of linguistics may result in an incorrect and incomplete understanding (Gadamer, 2006). Being reflective about translation, I decided to use my mother-tongue fluency Cantonese language in the research process to achieve a better understanding of speech and avoid any meaning being lost in translation.

> *'All other forms of language and speaking are not made the object of analysis, only the statement … Only that which the statement itself reveals through its being said constitutes the object of analysis and the foundation of logical consequentiality' (Gadamer, 2006, p.21).*

A verbatim translation of the data into the presentation language would be a better account for linguistic and cultural differences (Oxley *et al*., 2017). Temple and Young (2004) argued that techniques such as back-translation can be used to ensure agreement of the 'correct' version of a text. Such is not the case in this study, however, because the translation will lose meaning from the original languages, as Buddhist language and statements are difficult to translate into English.

> *‘What powers that we lack that enabled them to do this is a question for the researcher in religion, the cultural historian, and also the philosopher who is really at home in Chinese language and culture (it seems he can never be found!)’ (Gadamer, 2006, p.23).*

I employed a research assistant to translate transcripts verbatim, which allowed me to check for any translation inconsistencies. The original Chinese transcript was used for coding and conducting a TA. Researchers should listen to audio-recordings to focus on empathy and meaning as well as critical questioning and engagement in the hermeneutics stance (Smith, 2011; Rodham *et al*., 2015). The data analysis process maintained an open-minded and reflexive attitude to facilitate the exploration of such meanings. I discussed my perspectives and my findings in a transparent manner at every step of the process to achieve consistency and establish intersubjectivity. The recognition of how to construct meaning from participants and how to effectively communicate with the reader is key. This is why my choice of the two analytical, interpretative frameworks to allow the participants’ meanings to reveal themselves was made.

3.8 Choice of Two Analytical and Interpretative Frameworks

The process of reflection involves the 'self as a researcher' during the research knowing-in-action journey (Wigley, 2013). It is a process that reflected what I do know and what I do not know. Braun and Clark (2006) argued that TA is relatively easy to learn and conduct with flexibility in the social and psychological interpretation of data, which should be a foundational method for qualitative analysis. The strength of TA is that it can highlight the similarities and differences across each participant's dataset and generate insights from a large dataset. The disadvantage of TA is that it does not allow the researcher to make claims about language use (Braun and Clark, 2006). The lack of substantial literature and philosophy may furthermore make it difficult to develop guidelines for higher-phase analysis, the flexibility of which may lead to inconsistency in the formulation of common themes and pattern (Nowell *et al.*, 2017). For example, consider the Indian fable of the blind men and the elephant, in which some of the feelers-of-elephants were given the task of describing what the elephant ‘really’ is (Ihde, 1977). The first blind man felt the tail of the beast and perceived that the elephant was really a long snake. The second blind man felt the elephant's leg and described the elephant as like a tree trunk, rough and sturdy (Ihde, 1977). I presume the fable makes a valid point that parts should not be taken for the whole. The ‘phenomenon-elephant’ is just like the journey of breast cancer, despite patients’ limited access to the ‘elephant’, which has different horizontal and vertical interpretations.

Every participant’s story was just like the first blind man who described the elephant's tail in horizontal terms. The women each have unique feelings towards mastectomy and the experience of being breast cancer survivors. The analysis process is just like feeling the fluffy, coarse, and knotty-boned tail of the elephant. The researcher addresses the coping phenomenon not only in terms of body image but also regarding the effects the surgery may have had on their family, work, and psychosocial well-being. The choice of TA is intended to understand the participant's lived experiences in more depth including being a mother in their lived world. However, the blind men do have ‘the thing itself’ before them. Nine of the participants practiced Buddhist faith before they developed breast cancer (‘the thing itself’ for the purposes of the present study). The limitation of TA is that it cannot dig further into their descriptions of their historical being, which is their religious beliefs and traditional culture.

Interpretive phenomenology tries to create a particularly open way of empirical observation to explore a new vision towards things. I could not describe the entire Buddhist coping phenomenon in short. To define the reality of the elephant is difficult, not only before examining the whole but also before describing its parts (Ihde, 1977). The second blind man feels the pliable leg skin of the elephant, which is vertically lined and like the rigid bark of a tree. The second uses the van Manen method to examine the limited existential experiences from their lifeworld and what is ‘intuitive’ refers to logical transparency with sufficient precision. When I constructed the data analysis, I described that it is reflection-in-action (Wigley, 2013). I chose to apply the hermeneutic circle, which describes parts of the existentialist perspectives, as if masked by superficiality. The lifeworld consists of several aspects including the ‘lived space’ (spatiality), the ‘lived body’ (corporeality), the ‘lived time’ (temporality), the ‘lived human relations’ (relationality). and the ‘lived things and technology’ (materiality) (van Manen, 2014).

In more recent times, John Paley (2017) began a lengthy critique of the phenomenology method including the work of Amedeo Giorgi, Jonathan Smith, and van Manen. How is the meaning attribution done? The lived experiences and the essences are described from factually observed events. The meaning-making process is an ongoing intuitive phenomenological reflection to imagine the participant's meaning of experiences as if lived by the researcher (van Manen, 2017). For example, we can imagine the situation and understand Heidegger's anecdotes of ‘being bored’ of waiting for a long time in the train station (van Manen, 2017). Notably, the meaning attribution may sometimes be confusing in terms of which ideas came from the participants and which ideas came from the researcher's prejudices and projections.

I appreciate van Manen's phenomenology method. The strength of van Manen's method (2014) explains how insights are formulated in exploring the texts of lived human experiences; these are done using (1) whole reading, (2) selective reading, and (3) comprehensive reading approaches. The van Manen method provides step-by-step instructions in detail. The researcher can understand their challenges, such as ‘being fearful of cancer recurrence’ and how a Buddhist would deal with their situation in the four dimensions of the existential themes of life, in more depth. Therefore, I decided to choose the analytical and the interpretative data analysis methods, which include TA and the van Manen method.

3.9 Chapter Summary

This chapter introduces the philosophy of Heidegger's and Gadamer's phenomenology. Adopting a hermeneutic phenomenological stance based on the philosophical orientation of Gadamer, I was honest in the data collection and analysis with an open manner, acknowledging my prejudgments. The hermeneutic circle is an interpretation of meaning in a step-by-step process. Finally, the challenges in translation and the choice of two analytical frameworks were explained. In the next chapter, the research process is presented.

Chapter 4: Research Process

4.0 The Choice of Hermeneutic Phenomenology

Gadamer is a contemporary interpretive phenomenologist who inspired nursing research focusing on faith and cancer. For example, Granero-Molina *et al.* (2014) applied Gadamer's philosophical hermeneutic approach to define the phenomenon of faith in end-of-life care and found that the nurse–patient relationship could help in determining spiritual needs and facilitating the coping process in cases of terminal cancer. This is why the research method was applied in this study. The study is not just about breast cancer survivors describing their experience; it is also about understanding the meaning they derive from the things they perceive, as well as indicating the past and present cultural values that underpin these events. The rationale is described henceforth.

A first point to make in this regard is that strict adherents to Husserl's transcendental method (e.g. Amedeo Giorgi) insist that, when the object of phenomenological description is identified solely through intuition and interpretation, it is viewed as a distortion, a case of incomplete intuiting (van Manen, 1990). For pure description and intuition, it is difficult to reach the other people's conscious minds and thoughts, which was a complication in this investigation. Despite the phenomenological attitude, it is also difficult to bracket off all of our beliefs, assumptions, and values. Secondly, hermeneutic phenomenology is applicable to the study of interpretation in the field of religion. The hermeneutic tradition is rooted in the interpretation of God's message and meaning as indicated by Saint Augustine (Parse, 2001). Gadamer aligned himself with Heidegger's thoughts concerning the relationship between Christian religion, theology, and philosophy and the role these played in Heidegger's life and thoughts (Crowe, 2006). Jean-Louis Chretien led theological phenomenology in searching for the meaning of prayer in ‘the call and the response’, where the praying voice places the person closer to God (van Manen, 2014). Third, the focus of the current study will be on breast cancer survivors’ perceptions of self and body image and their Buddhist beliefs and practices following the reappraisal of traumatic events. Hermeneutic researchers focus on 'existential dimensions' that explore a person's sense of self, space, time, and embodiment (Finlay, 2006). The process of hermeneutic interpretive phenomenology is thus circular rather than linear (Streubert and Carpenter, 2007). Fourth, hermeneutic interpretation provides a broad, in-depth understanding of cancer survivorship from a researcher's perspective. In this regard, it seems a legitimate hermeneutic requirement to imagine ourselves in the situation in order to better understand its particular historical horizon (Gadamer,1988). Gadamer’s hermeneutic interpretation is both iterative and inductive; therefore, perceptions, experiences, and the individual meanings of the participants will all be explored (Finlay, 2011). The original meaning of interpretation is that of pointing to something and thus interpretation in this research refers to pointing out the meaning of something (Gadamer, 1976; van Manen, 1990). For instance, cancer survivors may describe anxiety experiences, and further exploration then indicates the reasons for worrying as involving the prognosis, side effects of the chemotherapy, and/or financial problems. As human behaviour is described, the meaning of behaviour can be further understood by the process of interpretation. Finally, the hermeneutic approach is both flexible and reflexive in the nature processes of contextualisation and amplification that aim to create rich, deep accounts of human experiences (Hein and Austin, 2001).The purpose of hermeneutic phenomenological reflection is to grasp the essential meaning of a phenomenon in multidimensional and multilayered ways (van-Manen,1990, Heinonen, 2015). This study therefore employed hermeneutic phenomenology as a method involving a small number of participants.

4.1 Sampling Strategy

The social sciences often conduct research using nonprobability sampling (Berg, 2004). Seidman (2013) suggested that the sampling strategy should include both purposive (e.g., homogenous) and maximum variation sampling. Purposive sampling should aim to recruit information-rich participants based on their specific knowledge of a phenomenon (Carpenter, 1995). Breast cancer survivorship was defined as commencing with the breast cancer diagnosis, through the completion of primary treatment, and continuing until the end of life (Pieters and Heilemann, 2011). The phenomenological approach focuses on an in-depth understanding of interviewees' experiences using a step-by-step procedure; the investigator therefore selects well-defined and homogenous samples (Dean *et al*., 2006). Homogenous samples include breast cancer survivors with identical Buddhist beliefs and the recruitment of women who have performed a significant amount of religious practice in their daily life.

Snowball sampling was also used to recruit individuals who have had similar experiences. Thus, snowball sampling involved asking research subjects to obtain other potential interviewees. Using this form of dynamic social network was useful for discovering participants in hidden populations (Nieswiadomy, 1993; Noy, 2008). However, I predicted difficulties in the recruitment process so I did not set limitations that would exclude participants, for example, not recruiting those whose Buddhist practice was adopted from different schools. Furthermore, there was no preset ratio regarding the different Buddhist organisations, amongst which were those practicing Zen and Nichiren Buddhism. This was because the research was not aiming to compare rituals and practices from different Buddhist organisations.

The maximum degree of variation in the purposive sample occurred in relation to the different ages of women with breast cancer, as women of any age may have different perceptions and behaviours regarding responses such as stress, appraisal, and coping. Even though the disease stages are similar, women do not necessarily experience commonalities in continuing problems such as lymphedema and residual pain. Their faith, however, exerted a lifelong impact on their attitudes and behaviours. When researchers reflect on the essence of a phenomenon, it is in terms of searching for the purpose and meaning of life, which are embodied in long-term consequences rather than in those in the short-term. In short, the aim of the current research was to identify the impact of positive and negative aspects of spirituality along with any psychological well-being adjustment patterns. The criteria of recruitment were as follows:

Box 2: The Inclusion and Exclusion Criteria

Inclusion criteria

(a) Women who were survivors of any stage of breast cancer

(b) Women who had completed any kind of acute breast cancer treatment such as surgery, chemotherapy, and/or radiation therapy after one year

(c) Women who were able to provide written and verbal consent to participate;

(d) Women with Nichiren Buddhist beliefs from SGI (Hong Kong) and/or other Buddhist organisations

(e) Women who were able to listen and speak fluently in Cantonese during the interview

Exclusion criteria

(a) Women aged younger than 18 years

(b) Women who could not understand Cantonese and/or Chinese

4.2 Ethical Considerations

The central principle of human research ethics is participant protection, which highlights the need to respect the rights, safety, and well-being of the participants (ICH GCP, 2006). The Nuremberg Code's (1949) first statement is: 'The voluntary consent of the human subject is essential'. Principle investigators therefore have the responsibility to inform the subjects that they have the right to be informed, the right to consent, and the right to withdraw consent at any time during the research process (ICH-GCP, 4.4, 4.8, 4.12, 2006). The 20 essential elements of informed consent include the study purpose and associated arrangements, the potential benefits and risks, the participant's rights and responsibilities, personal data protection, and compensation and costs (ICH-GCP, 2006; Yau *et al*., 2009). On 9 April 2015, I submitted my research proposal approval (Appendix B) to the ethics committee. The Faculty Research Ethics Committee granted ethical approval on 8 July 2015 (Appendix C).

4.3 Method of Data Collection

1: Access

A sealed invitation letter was given to Non-Governmental Organization (NGO) staff and SGI district leaders to distribute to participants. The response time limit was set within four weeks. There was an emphasis on participants' right to withdraw from the study at any time and without any disadvantageous consequences (Brett *et al*., 2010). If participants were willing to talk, they could contact me directly by phone to arrange an interview.

2: Recruitment

Starting in April 2015, I contacted a network of cancer support service organisations including the Hong Kong Cancer Fund (HKCF), the Hong Kong Anticancer Association (HKACA), the TSCA, and the Buddhist organisation of Hong Kong SGI. I requested their assistance in recruiting participants for my research study. The HKCF and the HKACA replied that they did not have any information on the religious affiliation of their members and therefore could not offer assistance in the recruitment process. The HKSGI and TSCA chief executives verbally agreed to facilitate informal contact with potential participants.

3: Sampling

However, the initial response was unsatisfactory; only two participants (P1 and P2) were interviewed in September 2015. Consequently, the top-down sampling changed to a bottom-up recruitment strategy. In October 2015, I contacted the local district (Tuen Mun and Hong Kong) leaders of HKSGI and provided them with information leaflets to distribute to those members who fulfilled the inclusion criteria. Furthermore, I contacted the Chinese University's Alumni secretary of the Religious Department, who was a member of the Buddhist organisation Fo Guang Shan (Tsuen Wan). She then introduced me to one participant (P4) for my study. Additionally, the sampling strategy improved following the use of a snowball sampling method, which delivered satisfactory results. Once the participants (P1 and P4) had completed the second interview, I invited them to contact other potential participants for my study. Three women (P3, P5, and P9) were then recruited using the snowball sampling method. The HKSGI leaders were supportive and seven other women (P1, 2, P4, P6, P7, P8, and P10) subsequently contacted me by telephone.

None of the interviewees were personally known by me. Once 10 women had expressed an interest to participate, the recruitment process was complete. I then notified the local district leaders that I had achieved the number of 10 participants and ceased recruiting on January 2016. There were no late respondents.

4.4 The Researcher's Liability Regarding Data Protection and Security

The researcher’s responsibilities involved following the Belmont Report (1974), where the key principles are respect for persons, beneficence, and justice (Vijayananthan and Nawawi, 2008). The researcher is committed to protecting all of the participants’ identities and ensuring confidentiality through a process of gathering written informed consent (Appendix D). All identifiable information such as the locations of homes needed to be removed in all published research. I therefore used pseudonyms for participants in all of the research records and the field diary. All data was therefore guaranteed to be anonymous and confidential in line with the Data Protection Act (1998). All written and electronic data were designated to be destroyed following the completion of the thesis.

4.5 Participant Safety and Risks in the Process

The common rule across institutional review boards is that no one must be harmed by the research (Lo, 2010). I therefore had the responsibility of identifying all potential risks so that I could avoid or alleviate them (Appendix E). For example, Gloria (P7) became distressed when talking about her ulcerative wound after radiotherapy. She then suspended the interview until she felt comfortable enough to continue the interview. Five minutes were required to provide space for her sadness and allow her to change from being upset to feeling relaxed. The researcher also showed empathy, caring, and kindness towards her. There was no perceived need to provide counselling referrals to support services.

4.6 Researcher Safety

There could have been some potential risks to the researcher, but these were carefully minimised. Before each interview, I would ensure my own safety by notifying my husband of the venue and my expected time of return. I ensured I always had with me a mobile telephone with sufficient battery life remaining. After conducting the interviews, I felt that I often resonated with the interviewees' feelings of anxiety and stress. To address this, I practiced chanting and meditation to cope with the stress. Overall, I did not experience any significant risks throughout the duration of the data collection process.

4.7 Arrangements for the Interviews

4.7.1 Interview Schedule

I recognised my desire to achieve a partnership with the participants so that our interaction was equal with no superior or inferior attitudes on women interviewing women. Furthermore, I considered my dress code to initiate a friendly impression, avoiding formal dress to reduce any power differential during the interviews. I selected smart casual clothes to put myself at ease in the whole process. I reflected on her preconceptions regarding the loss of a breast which depended, to some extent, on the value attached to ‘femininity’. I felt I needed to be sensitive to their feelings and their husbands’ needs and concerns.

All 10 of the participants signed the informed consent form before starting their interviews. I first explained the aims in detail and introduced my SGI Buddhist disciple's identity. I also showed them University of West of England (UWE)’s ethical approval and my UWE student-card. To avoid any misunderstanding, I declared there were no conflicts of interest, as it was a self-financed research study. I used a digital recorder and a good-quality microphone.

The first interview commenced on 30 July 2015 and the final interview was completed on 14 September 2016. The first interviews ranged from 32 to 64 minutes in length and the second ranged from 36 to 70 minutes in length, respectively. All interviews were transcribed verbatim. Flexibility and refinement to the schedules were allowed if needed.

I strived to cultivate a friendly atmosphere so that the interviewees felt free and open to talk about their experiences. I saw Amy's, Elsa's, and Gloria's husbands and Helen's parents in their homes. Some conversations with the participants' partners provided interesting context regarding how significant others had contributed to the women's experiences and had supported them in fighting cancer.

My observations as a researcher were recorded in my reflective diary, noting especially the demeanour of participants during the interview and any responses and/or behaviours.

4.7.2 Interview Locations

A choice of location was offered to all participants. Each interview was arranged by agreement between the researcher and the participants. Participants choices generally varied (Table 5). The researcher needed to be aware of the norms and traditional values that underlie people's behaviours (Rubin and Rubin, 2012). There were no refreshments provided, although a cup of warm water was available if needed. The privacy of each interviewee was protected by the use of a single self-contained room and all the interviews were conducted without any interruptions. Eleven interviews were conducted in the Buddhist organisation or at the Alliance International Education office. Nine interviews were conducted at the participant's home or office. There were no withdrawals or refusals in any of the 20 interviews.

4.7.3 Choice of Spoken Language

Language is the horizon of hermeneutic ontology (Heidegger, 1962; Gadamer, 1976; Parse, 2001). Language-view is a worldview in that language has its true being only in dialogue (Gadamer, 1994). This study mainly recruited Cantonese speakers who understood both oral and written Chinese and Cantonese. The use of a native language and language consistency in a study is highly recommended (Yau *et al*., 2009). Short, simple layman's language facilitates better understanding. Consequently, all participants provided verbal and written consent in Chinese. Moreover, speakers of other Chinese dialects were excluded. This was because if was felt that the investigator would find it difficult to understand them, which may have led to their experiences being misinterpreted.

4.8 Formulating Interview Questions

Qualitative inquiry is flexible and elastic in nature. The questions that are asked tend to be holistic and strive for an understanding of the whole through the use of unstructured, semistructured, or structured interviews (Silverman, 2010; Polit and Beck, 2014). The focus is on the essence and meaning of the phenomenon as experienced by people. The first and second interviews were completed within eight weeks. The relevant data were obtained from the 10 participants using semistructured, face-to-face interviews in order to capture emergent themes. The interview process comprised three stages: (1) the initial apprehension phase used to develop rapport; (2) the exploration phase, which involved in-depth descriptionl and (3) the co-operation period, which clarified certain points that helped make sense of the world (DiCicco-Bloom and Crabtree, 2006). Pope and Mays (1996) pointed out that qualitative studies often ask questions such as what and how does the phenomenon vary in different circumstances and why. Rubin and Rubin (2012) suggested that effective interviews included the central research questions, probes to encourage talk in the subject, the provision of examples, and follow-up questions that ask interviewees to elaborate on key concepts, themes, and/or events in greater depth. For example, the anthropologist Bronislaw Malinowski lived within the native communities he was studying and conducted unstructured interviews as part of both ethnographic and anthropological traditions. He gathered descriptive data through long-term participation and observation in order to understand the cultural context of these communities and interpret the meanings associated with their behaviours (Chambers, 2003). Health care researchers commonly use individual, semi-structured in-depth interviews ranging from several minutes to hours in length in order to obtain a life history (DiCicco-Bloom and Crabtree, 2006). Data collection is normally concerned with how the individual feels about the phenomenon and the impact it has on them from a cultural perspective; questions might therefore be asked using descriptive, exploratory, or interpretative approaches (Clifford, 1997). This bears in mind the key definition of interview whereby ‘inter’ means in between and ‘view’ means vision (Seidman, 2013). What, therefore, does it mean to be a breast cancer survivor? The meaning of an event (diagnosis of breast cancer) to the person (varied range of age of the survivors) shapes their emotional and behavioural responses. The personal interviews were provided for immediate clarification and observation of each participant’s thoughts and nonverbal cues, such as gestures and facial expressions (Penner and McClement, 2008). To facilitate the collection of rich data, personal in-depth semistructured interviews were specifically designed to gain insights into the experiences of the participants. Data included perceptions, values, and feelings around being a breast cancer survivor. All interviews lasted from 32 to 70 minutes. At their conclusion, I presented a brief summary of the interview to the participant to allow for any misunderstandings to be clarified.

4.8.1 First Interview

Patton (1990) and Berg (2004) suggested that the first steps in interview construction involve developing a general outline and listing all of the broad categories. Brinkmann and Kvale (2015) advocated for the use of an open, introductory question that may help to yield spontaneous, rich descriptions of the phenomena investigated. Open-ended questions were adopted throughout the interview so that respondents were completely free to frame their answer as they wished (Frey and Oishi, 1995). The specific ordering and wording of questions must, however, adhere to the central aims of the study, as significant variation in this may significantly affect the findings (Berg, 2004). Therefore, each interview began with mild and nonthreatening questions. The first few questions focused on exploring the experiences of living with breast cancer by investigating the participant's knowledge, understanding, perceptions, and experiences of the disease, for example, first, 'please tell me about your story of breast cancer diagnosis.' The follow-up question to this then was 'please tell me about your experience in receiving treatment'. The researcher would sometimes nod or pause, which would invite the interviewee to continue with the description. The third question was "what problems/stress do you perceive in your cancer journey?' or 'could you please talk more about the source of stress or difficulty during the treatment period? It could be related to physical, psychological, social, financial, symptoms or any other aspects'. The final question was 'what was your greatest source of stress?' The participants were then thanked for their participation.

Probes were used when required to clarify the meaning of responses, for example, 'could you give me an example?'. Probes included simple gestures such as saying 'uh-huh' or simply nodding (Frey and Oishi, 1995; Silverman, 2010). On occasion, paraphrasing or repeating significant words within an answer could lead to further elaboration. Overall, the study led me towards a deeper understanding of what it means to be a breast cancer survivor in Hong Kong. The aim of the phenomenological interview was to interrogate something from the heart of our existence—from the centre of our being (van Manen, 1990). It was important, therefore, that each question was open and able to reveal or draw out something of an object through authentic dialogue (Gadamer, 1994). Brinkmann and Kvale (2015) suggested that more direct questions should be postponed to later parts of an interview. In my research, such questions asked about the participant's faith and practices using their own spontaneous descriptions and thereby indicated which aspects of the phenomena were central to them. Interview length depended on the type of answers generated and shared between the interviewer and interviewee. The conversation flowed in a way such that the same question might elicit short and simple answers from some participants and rich and detailed answers from others.

4.8.2 Second Interview

Prior to starting the second interview, I interpreted the meaning of the first interview from the participants’ perspectives. For example, the first question asked ‘do the Buddhist beliefs help you cope with the above problems? If yes, how?’. This was because it was important to understand the role of a specific Buddhist philosophy and cultural beliefs in coping. This question was asked twice in both the first and second interview to avoid a longer conversation. This question required more detail in the second interview in order to clarify and explore more deeply the patient's mind and conscious intentions, thus reflecting the essence of the phenomenon.

Question was derived from the Systems of Belief Inventory (SBI-15R) developed by Dr. Jimmie Holland. In 1992, Holland developed SBI-15R to address patients’ religious and spiritual beliefs when coping with cancer issues (Holland *et al*., 1998). SBI-15R was a brief self-report inventory that assessed QOL and psychosocial adjustment to illness (Holland *et al*., 1998). The instrument was divided into two scales, as follows: the Belief Scale measured spiritual beliefs and practices, whilst the Support Scale measured social support in relation to the respondent’s religious community (Holland *et al*., 1998). The SBR-15R was very useful in developing questions for the second interview. For example, the second item in this inventory was ‘prayer or meditation has helped me cope during times of serious illness’. This was because many people might view themselves as spiritual rather than formally engaged in religion. Religious beliefs, practices and rituals, however, were more easily understood. The second interview focused on understanding the role of specific Buddhist religious beliefs and their spiritual impact on Chinese women who have survived breast cancer. How does Buddhist coping vary amongst different breast cancer survivors? Probes could be verbal, such as ‘could you tell me a little more about that?’ or ‘Go on—this is great’, whilst nonverbal probes included waiting for the interviewee to continue or leaning forward to express interest (Rubin and Rubin, 2012).

The questions were therefore based on basic Buddhist theory. The role of the positive and negative aspects of spirituality such as ‘embitterment and enlightenment’ were related to breast cancer survivors’ psychosocial well-being (Chan, 2008). Zen Buddhist thought states that phenomena are interdependent and empty of essence; hence, it is a philosophy centred on emptiness (McCaffrey and Moules, 2012). This is similar to the concept of phenomenological bracketing, which is based on ‘back to the things themselves’ principles. Other questions included ‘How do you practice your beliefs, such as through meditation and praying?’ and ‘How frequently do you practice?’ (e.g., Nichiren Buddhism’s everyday chanting of the Lotus Sutra/your own beliefs, describe the practice and action of the informants). Questions were designed to explore their primary, secondary, and cognitive reappraisal coping processes. Frey and Oishi (1995) suggested that the phrasing of the questions should be neutral and consistent with previous questions in the interviews. The adaptation process might, for instance, be inherently circular in terms of their long-term survivorship. The second interviews ended with a summary at the end. I was therefore as concrete, specific, and simple as possible when summarising their experiences prior to concluding the interviews. The variation in transcript lengths reflected individual differences in participants regarding whether they had an introvert or extrovert personality and/or their explanations on practicing meditation and method(s) of praying. I did not set any boundaries for this question nor limit their answer regarding religious and spiritual experiences to ensure their rights were protected.

4.8.3 Other Data Resources

Three additional sources of data were the researcher's field notes, a critical reflective research journal, and the magazine and newspaper of the Hong Kong SGI.

4.9 Data Analysis

The data helped to capture salient themes as described by the women. Researchers need to ensure trustworthinss and analytic credibility with regard to coding, categorising, decontextualizing, and recontextualising data (Starks and Trinidad, 2007). The current study therefore employed a two-stage thematic and phenomenological data analysis. The first layer of data analysis followed the process of TA as described by Boyatzis (1998) and Braun and Clarke (2006). The holistic approach involves reading the text as a whole to identify emergent themes (Reiners, 2012). The second layer of data analysis follows the process of phenomenological reduction as described by van Manen (1990). This selective approach extracts essential statements pertaining to the lived body, lived time, lived space, and lived relations (van Manen, 1990;   Reiners, 2012). I therefore engaged in a reflective process to utilise the hermeneutic circle method of analysis, which was under continual review (Reiners, 2012; Johnson, 2016). Common themes were identified between the participants' individual thematic maps. I had also attended a two-day course on the use of NVIVO 9 (17–18 May 2016) which was prepared by UWE.

4.9.1 Thematic Analysis

TA is a process involving the compilation or integration of many codes; it is not only a way of seeing but also a way of making sense out of qualitative information (Boyatzis, 1998; Braun and Clarke, 2006). The TA comprises a process of observation that can be applied to a person, group, interaction, or culture and is often called pattern recognition (Boyatzis, 1998). This, as described by Boyatzis (1998) and Braun and Clarke (2006), entails three different approaches: a theory-driven approach, a prior-research-driven approach, and a data-driven approach. The data-driven approach was more appropriate for my research topic. Data thus drove the process of formulating structure and patterns in the phenomenon without any prior theorising (Boyatzis,1998). Boyatzis (1998) suggested that the researcher examine the sampling of units of analysis and units of coding from multiple perspectives, and that an expert (such as my supervisor), review the appropriateness and adequacy of the interpretation of meaning. Boyatzis (1998) and Braun and Clarke (2006) also detailed repetitive steps including identifying themes within subsamples and then comparing themes across subsamples, with the focus on creating a code and determining its reliability. A constructed statement (code) could be used to write and rewrite each theme, eventually creating maximum differentiation between the two subsamples. The findings were therefore driven by the data through the clarification of the unit of analysis and the unit of coding

(Table 3). Boyatzis (1998) further suggested that coding commences with labelling. The process requires the researcher to engage in an ongoing reflexive dialogue with the data (Braun and Clarke, 2006). The major obstacles to this are the researcher's (1) projections, (2) sampling, and (3) mood and style in the data collection and analysis process, and therefore the researcher should not be preoccupied when conducting such (Boyatzis, 1998). Each meaning code or a label should include a definition of the characteristic or issue constituting the theme and a description of how to recognise when the themes or pattern occurs (Boyatzis, 1998).

4.9.2 The van Manen Hermeneutic Interpretation for Meanings

The second layer of data analysis follows the phenomenological approach as described by van Manen (1990). To eliminate confusion, the researcher followed the van Manen hermeneutic reduction steps set out in Table 3. Phenomenology is a meaning-giving method of inquiry applied to a special phenomenon that reflects different ways of understanding (van Manen, 2014). The participants have a special mindset in relation to the Buddhist coping mind and meditation practices; therefore, the above theories might not apply to other breast cancer survivors. This is due to individual differences between the ‘living now’ and the ‘mediated now; and the fact it is difficult to capture the ‘now’ of the lived experiences of the participants. Furthermore, the participants’ words were used throughout the process of data analysis and phenomenological description. Utrecht, the Dutch approach, includes two options for interpreting meanings, as follows: the holistic approach whereby the researcher reads the text as a whole and makes sense of the story and the selective approach in which the essential statements from the informants are extracted using a detailed method that analyses every sentence (Reiners, 2012). Although a computer NVIVO 9 program was available to assist with the frequency count and coding of significant terms in the transcripts, analysing the meanings of the phenomenon was still a complex and creative process that had to be made sense of by the researcher. van Manen (2014) explains how insights are formulated in exploring the texts of human lived experiences; these are (1) in whole reading, (2) in selective reading, and (3) in detailed reading approaches. van Manen (2014) also gives an example of a description provided from memory by an adult telling the story of his hidden secret of drinking alcohol when he was 12 years old. The childhood secrecy experience is converted into an anecdote and the texts examined in terms of the holistic meaning of hiding our ‘self’, the identity of a sense of self-guilt, and line-by-line thematisations of the child's experience in maintaining secrecy from his parents. van Manen's data analysis method included the description and interpretation of the meaning of the investigated experience. Furthermore, the phenomenological findings would remain open-ended because the participants' perspectives might change over time and thus new meanings may be found in the different structures of a phenomenon (DeRobertis, 1996).

The hermeneutic reduction of van Manen's method focuses on the meaning of the 'lived experience' and explores the interpretative meaning of the participant's 'lifeworld' (van Manen, 1990; van Manen, 2014; Heinonen, 2015). The lifeworld consists of several aspects, including the 'lived space' (spatiality), the 'lived body' (corporeality), the 'lived time' (temporality), the 'lived human relations' (relationality) and 'lived things and technology' (materiality), which are the existential themes of life (van Manen, 2014; Heinonen, 2015). For instance, some informants (Dora, Fanny and Iris) perceived suffering as a temporary situation. Even though unexpected major events may threaten, harm, or challenge an individual, they might differ from the personal and time factors that constitute a dynamic person–situation relationship. Some participants (Dora, Iris) also perceived breast cancer to be an opportunity to engage more in their Buddhist beliefs and practices. These participants focused on solving their problems and emphasised the entry point of changing feelings, thoughts, and actions by embracing their Buddhist beliefs and meditation.

4.9.3 Data Analysis and Interpretation Process

The process of analysing the narratives was guided by steps as per the Braun and Clarke and van Manen research methods (Table 3).

Table 3: Data Analysis

Step 1:

Braun and Clarke's steps are:

1. Familiarsing yourself with your data

2. Generating initial code

3. Searching for themes

4. Reviewing themes

5. Defining and naming themes

6. Producing the report

(Braun and Clarke, 2006, p.35)

↓

Step 2: The van Manen Steps of Hermeneutic Phenomenology

The van Manen steps of Hermeneutic Phenomenology are:

1. Turning to a phenomenon that seriously interests us and commits us to the world

2. Investigating an experience as we live it rather than as we conceptualise it

3. Reflecting on the essential themes that characterise the phenomenon

4. Describing the phenomenon through the art of writing and rewriting

5. Maintaining a strong and orientated pedagogical relation to the phenomenon

6. Balancing the research context by considering both parts and the whole

(van Manen, 1997, p.30)

(1) The analysis began by reading the whole text of Helen's story (Appendix F) to obtain an understanding of the content, because the meaning of the entire text will influence the perception of its parts. Phase 1 shows the example of Helen's second interview (lines 1–10) including the coding system employed. The overall insight is that Buddhist beliefs helped her to overcome her difficulty.

(2) Phases 2 to 4 illustrated the code book creation and modification through the coding method (Appendix G). Every sentence or section was investigated to get the text's answer (the horizon of the text) as to the meaning of Buddhist coping to improve or restore health and well-being. Themes were identified that challenged the researcher and their pre-understanding of the studied phenomenon (the horizon of the researcher).

(3) Phases 5 and 6 focused on the van Manen method that categorised into four lived domains. Every sentence or section was then related to the meaning of the whole text as revealed in the initial phase and, thereby, the sense of the text was expanded.

(4) Themes that were representative of the shared understanding between the researchers and each participant, for examples include 'I am a Buddhist'. Please refer to 5.4 Section 2 (interpretative understanding of shared experiences) for more information.

Phases 1 through 6 were as follows.

Phase 1: Segmentation of Text: Example of Helen's interview 2 (Lines 1–10)

1. K: I have invited Ms. Helen, patient 8, to accept a second interview. She has signed a consent form. I would like to ask if your Buddhist belief has assisted you.
2. P8: I thought it helped me a lot. It enabled me to enhance [my] positive strength and to overcome every difficulty. I felt less pain. I accepted myself no matter [if] it was good or not. I accepted whatever happened to me.
3. K: What were the difficulties for you? Could you please give an example?
4. P8: In fact, I had felt I was inferior since I was small. I lacked confidence. Chanting daimoku enhanced my confidence. If I encountered something that I was not able to handle, I would accept my failure to do it. I prayed and hoped and I continued to put in great effort and proceed every day. There was a hope that I could achieve the target in the future.
5. K: Could you please tell me what you targeted to do? Could you give an example?
6. P8: In fact, I intended to bring up four children. I hoped that they placed trust in ‘Gohonzon’ and were able to overcome the obstacles. Their lives were moving forward. They could grow up happily.
7. K: The motivation for overcoming the breast cancer was to look after your four children. Was that what you meant?
8. P8: Yes, it was. I thought my greatest mission was to bring them up and look after them. They grew up healthily and happily.
9. K: You underwent medical treatment for more than three years. How did you feel during this time?
10. P8: I kept making progress. Due to this sickness, I found that everything could be achieved on the condition that you placed trust in ‘Gohonzon’. It depended on whether you were willing to put in the effort and were willing to do it. I stepped up my efforts to overcome the difficulty and bear the hope. I should not grumble. I could achieve the target if I continued to put in the effort.

Phase 2: Codebook Creation: Example of Initial Codes

Interview's thematic codes:

Helen's Interview 2: the data via transcripts	First coding	Second coding
It (Buddhist beliefs) helped me a lot	Positive helping	I was a Buddhist
Enabled me to enhance the positive strength	Psychosocial impact of Buddhist faith	Being: positive strength, self-empowerment
Overcome every difficulty	Action to cope	The Lived Space: action
I felt less pain	Illness and painful lived experience	The Lived Body of suffering
Accepted myself	Acceptance of survivor's identity	Karma coping
Accepted whatever happened	Acceptance of fate and impermanence	Wisdom-based coping
I was inferior since I was small, *I lacked confidence*	Childhood experience	Inferior self-identity
Chanting enhanced my confidence	Chanting effect	The Lived Time of self-recognition
Accept my failure	Acceptance	Emotional coping
I prayed and hoped	Praying: chanting effect, hope	The Buddhist coping essence
I continued to put in great effort	Problem-solving action	Transform the negative karma
There was a hope	Initiate hope	Mood-dwelling
I could achieve the target in the future	Self-efficacy	Future: Yes, I can
I intended to bring up 4 children	Motivation from caring to family	Fulfilling of her mother role
They (four children) placed trust in 'Gohonzon'	Trust in Gohonzon	The Lived Relation with 'Gohonzon'
Trust in 'Gohonzon' able to overcome the obstacles	Confidence to overcome the obstacles	That was a good arrangement of 'Gohonzon'
Grow up happily	Her children were happy	The happiest experience
My greatest mission was	life meaning	Enlightenment
To bring them up and look after them	Self-fulfilling mother role	Being-with-others Desired to live longer
I kept making progress	To do something	Positive

		problem-solving, coping
Everything could be achieved	A sense of self-confidence by faith	Grateful to a good arrangement of 'Gohonzon'
You placed trust in 'Gohonzon'	Being: Trust	Buddhist coping
Willing to put in effort	Positive problem solving action	Compassion
Willing to do it	To do something	Courage to cope
Stepped up my efforts to overcome the difficulty	Strong will to survive	Wisdom coping
Bear the hope	hope	The Lived Time: Hope
I should not grumble	Acceptance attitude	Personal growth
I could achieve the target	Yes, I can. Self-confidence by 'Gohonzon'	That was a good arrangement of 'Gohonzon'
I continued to put in the effort	Being-in-the-world: problem solving	The Lived Space: Continuous action

Phase 3 Codebook Modification: TA of Helen's Data

1. *I intended to bring up four children*	*I intended to bring up four children* *Grow up happily* *My greatest mission was* *To bring them up and look after them* *Willing to do*
2. *That was a good arrangement of 'Gohonzon'*	*Buddhist beliefs helped me a lot* *Enabled me to enhance the positive strength* *Overcome every difficulty* *I felt less pain* *They (four children) placed trust in 'Gohonzon'* *Trust in ;Gohonzon; able to overcome the obstacles* *Everything could be achieved* *You placed trust in 'Gohonzon'* *Chanting enhanced my confidence* *Accepted myself* *Accepted whatever happened* *Accept my failure* *I prayed and hoped* *There was a hope* *Bear the hope*

Phase 4: Reviewing Themes from Helen's First and Second Interviews

That was a good arrangement of ‘Gohonzon’	*I was quite worried but I also wished for the good arrangement of ‘Gohonzon’ (8/1/8).* *This was due to the good arrangement of ‘Gohonzon’. The first injection of chemotherapy after the surgery was also arranged in summer vacation (8/1/8).* *I strongly felt the strength of diamoku through my personal experiences in this sickness (8/2/157).* *I chanted in my heart. This made my mind more peaceful and I viewed the incident with a positive perspectives (8/2/19).* *The doctors and nurses took good care of me and the (Gohonzon) arrangement was good.* *My younger sisters and mother, especially the first younger sister, supported and encouraged me that I could have good (Gohonzon) arrangement and overcome the difficulty through chanting (8/1/90).* *‘Gohonzon’ had an influence on my optimistic attitude (8/2/41).* *I chanted for ‘Gohonzon’ in support of myself (8/2/63).* *I hoped that they placed trust in ‘Gohonzon’ (8/2/6).* *I found that everything could be achieved on the condition that you placed trust in ‘Gohonzon’ (8/2/10).*

Phase 5: Defining and Naming Themes of Helen's Lived World

The Lived Space	*I continued to put in the effort* *I continued to put in great effort* *Trust in 'Gohonzon' [made me] able to overcome the obstacles* *I kept making progress* *Willing to do* *I should not grumble* *I could achieve the target*
The Lived Body	*Present: I felt less pain* *Accepted myself* *Accept my failure* *Past: I was inferior since I was small,* *I lacked confidence* *Future: My greatest mission was to bring them up and look after them*
The Lived Time	*Chanting enhanced my confidence* *I prayed and hoped* *There was a hope* *Everything could be achieved* *You placed trust in 'Gohonzon'* *Bear the hope*
The Lived Relation	*Accepted whatever happened* *I could achieve the target in the future* *I intended to bring up four children* *They (four children) placed trust in 'Gohonzon'* *Grow up happily* *Willing to put in effort* *Stepped up my efforts to overcome the difficulty* *I continued to put in the effort*

Pseudonym of participant	Individual themes	Uniqueness of experiences
Helen Being: 1. I felt less inferior 2. I felt more positive and comfortable Being-with-others: 1. All family members, relatives, friends, doctors and nurses alike were very kind to me Being-in-the-world: 1. Her mission was taking care of her children	The Lived Space	1. The happiest experience was the support of the people around me
	The Lived Body	1. My body was fragile after I was discharged from hospital 2. I felt pain in my bones throughout my body
	The Lived Time	1. I spent more time on chanting when I was ill 2. I spent more time chatting with others 3. I thought the time had passed swiftly... three years had passed. 4. I felt that [the] hospitalisation (time) was slow
	The Lived Relation	1. There was a sharing group among the patients [for] giving encouragement and support to each other

Phase 6: Producing the Report on Helen's Final Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Helen Age at interview: 41 years Age at diagnosis: 38 years Being: *1. I felt less inferior* *2. I felt more positive and comfortable* Being-with-others: *1. All family members, relatives, friends, doctors and nurses were very kind to me* Being-in-the-world: *1. I intended to raise four children* *2. I wanted to help others, i.e., other breast cancer patients* *3. I thought that the impossible could turn to possible*	Theme 1: *I intended to raise four children* Theme 2: *I had regularly attended various seminars* Theme 3: *That was a good arrangement of 'Gohonzon'* Theme 4: *I had many supportive and caring people around me*	The Lived Space: *1. The happiest experience was the support of my family* The Lived Body: *1. My body was fragile after I was discharged from hospital* The Lived Time: *1. I spent more time chanting when I was ill* *2. I also spent more time chanting with others* The Lived Relation: *1. There was a sharing group among the patients that gave encouragement and support to each other*	Helen's identity and embodiment were focused on how to be a good mother. Her spatial and temporal mobility was her family. Although Helen was aware of her bad temper in educating her children, she could control her emotions after chanting.

4.10 Hermeneutic Phenomenological Reflection

The purpose of hermeneutic phenomenological reflection is to grasp the essential meaning of a phenomenon in a multi-dimensional and multi-layered way by communicating textually using organised narrative or prose (van-Manen, 1990). Qualitative researchers usually engage in reflexivity so that the researcher develops an awareness of these intersubjective dynamics (Finlay, 2006). This is because the researcher–text dialectic arises with a fusion of horizons (Parse, 2001). The researcher's subjectivity and his/her value are acknowledged because we are incapable of total objectivity (Ajjawi and Higgs, 2007). If the researcher is already familiar with the research field and setting, then special precautions must be taken to avoid threats to validity (Finlay, 2006; Finlay, 2011). The researcher should enter the setting as a 'stranger' in order to exert critical self-reflection. Steward (2006) suggests that, as researchers, we need to make our standpoint clear through a process of reflexivity that includes recording our social background, assumptions, positioning, and behaviour in a research dairy and mentioning the details if they are believed to have affected the investigation process. Foreknowledge and prejudices are constituents of meaning (Parse, 2001; Silverman, 2010). Here, the researcher acknowledged that they had presupposition and Buddhist beliefs prior to conducting the study. The phenomenological attitude requires a reflective mind that views lives as phenomena that should not be taken-for-granted. The researcher might or might not ask all of the questions in a semistructured interview. The explanations and views of the participants are presented from their point of view and situated within their context. Direct quotations, accounts, and stories provide illustrative insights during the data analysis process. Researchers should ensure trustworthiness and analytic credibility regarding the coding of the data (Starks and Trinidad, 2007; Finlay, 2011; van Manen, 2017). Interviews were transcribed and manual analysis was conducted. Yin (2011) argued that research procedures should be transparent and strive to be as faithful as possible; data should therefore always be available for inspection.

Phenomenologists from the Duquesne School include Colaizzi (1978), Giorgi (1985), and van Kaam (1966), who founded their approach on Husserl’s descriptive phenomenology (Giorgi, 2010; Laverty, 2003; Reiners, 2012). Beck (2013) suggest the most frequently used of these in published studies is Colaizzi's method (n = 310). Examples include nursing researchers interested in the experiences of nurse and nurse students (n = 103), patient experiences in childbearing (n = 41), and oncology patients’ experiences (n = 35). Colaizzi’s method validates findings by returning to the study participants and viewing them as coresearchers, whilst Van Kaam's method validates the findings through intersubjective agreement being reached with other expert judges (Laverty, 2003; Reiners, 2012; Polit and Beck, 2014). In contrast, Giorgi argued that it is not appropriate to challenge the psychological meaning of participants’ everyday experiences; therefore, asking the informants or an expert is not permissible (Giorgi, 2010; Reiners, 2012; Beck, 2013). Expert judges mainly focus on whether facts and themes listed under a category fit that category, which does not allow for free imaginative variation (Polit and Beck, 2014). Here, there was congruence with the tradition of an interpretative phenomenological approach; no external validation of interview or analysis was sought (Mitchell, 2015).

4.11 Addressing Trustworthiness in Qualitative Research

Lincola and Guba (1985) suggested that the trustworthiness of qualitative research comes from credibility (approximating to some degree of truth), transferability (that the findings can be applied to other studies), dependability (carrying out similar research will produce similar findings), and conformability (objectivity). Data saturation in grounded theory, for example, means there is no new information, new themes, or new codes and the study can be replicated in other settings (Denzin and Lincoln, 2003; Glaser and Strauss, 1967). This study could therefore ensure the findings have quality and rigour by using the following procedure.

4.11.1 Credibility as Compared with Internal Validity

Credibility is ensured when the researcher describes the purpose and the research method including how data were registered (Creswell, 1998; Denzin and Lincoln, 2000; Schou *et al*., 2012). Internal validity focuses on the methodology and external validity focuses on logical flow and credibility (Creswell, 2003; Offredy and Vickers, 2010). Nothing would therefore happen unless the researcher made it happen—they are captain of their own ship. Qualitative research requires a prolonged engagement in terms of time spent coding as well as persistent observation and the application of experience. The researcher therefore continually reflects on possible interpretations of participants views, as though they are a navigator helping to read a compass to sail the ship.

4.11.2 Is the Interrater Reliability Test Performed in This Type of Qualitative Research?

Once the interview has been transcribed, coding of the entire dataset commences and entails the inclusion of words, sentences, paragraphs, and responses. Coders, however, make judgments based on intuitive and heuristic perceptions that may introduce bias and prejudices. In short, different coders may interpret in different ways. Although there are different approaches to qualitative data analysis, coding is always a challenging aspect of the process. Coding involves compiling a list of defined codes (the codebook), searching for themes and patterns in each segment of the text, and then determining the meaning overall (Hruschka *et al*., 2004). Hruschka *et al.* (2004) proposed an iterative process of intercoder reliability taht includes the segmentation of text, codebook creation and modification, and final recoding. Cohen's kappa K provides a coefficient alpha for rating scales and represents interrater agreement and item reliability so that the quality of data can be evaluated (Dawn, 2001). Additionally, Krippendorff's alpha test aims to correct for the chance of agreement and is based on the logic of the chi-squared test and a generalisability theory approach (Dawn, 2001).

The first point to make, however, is that a phenomenological approach does not aim to generalise the results. I did not apply the interrater reliability test because such is used mainly for nominal datasets in some forms of quantitative research. It is a term derived from positivist and quantitative research that does not easily apply to qualitative research (Hruschka *et al*., 2004). Secondly, open-ended responses are not likely to yield a high degree of agreement between two or more coders (Hruschka *et al*., 2004). For example, in 1991, Kolbe and Burnett criticised the quality of content analysis in consumer research with applied interrater reliability tests. This consumer research asked two experts to code 60 print advertisements according to three categories, which were ‘emotional imagery’, ‘rational informative’, or ‘mixed ambiguous’ (Dawn, 2001). However, merely judging the percentage of agreement between two raters on the dataset cannot offer anything that explains the meaning of consumer behaviour. This was because there were small degrees of freedom for each coding choice. The fewer the number of themes and categories available, the more random was the agreement achieved. Thirdly, intercoder reliability is a very useful assessment of qualitative findings in multidisciplinary research and significant data produced in team-based work, such as at the US Centers for Disease Control and Prevention (Hruschka *et al*., 2004). For example, in a Zimbabwe study, 300 respondents randomly led to the selection of a specific sample of 60 participants (20%) to capture variation, and each coder independently established the code of the acceptability method to prevent human immunodeficiency virus. The team members discussed any problem until a consensus was reached regarding the inclusion/exclusion criteria used in the codebook (Hruschka *et al*., 2004). There is no need, however, for the current research to have intercoder reliability assessments. It employed a small sample size and was not multidisciplinary in nature. Finally, a hermeneutic data analysis focused on the researcher's interpretations. It would prove difficult to include another researcher with a Buddhist faith who is especially understanding of the rituals and meaning of various Buddhist terms.

4.11.3 Transferability as Compared with External Validity

Transferability refers to the selection of informants or sources as described and explains why these informants are selected (Denzin and Lincoln, 2003; Schou *et al*., 2012). The researcher described the sampling strategy and the method of data collection in a rigourous process. Furthermore, my personal values and experiences were written in my reflexive diary to ensure transparency, enabling me to map out my journey and organise my time properly. I therefore become a part of the phenomenon, which is the tradition of the hermeneutic interpretive school of thought (Reiners, 2012). Therefore, my preconceived ideas were not bracketed, which presented the construction of meaning as a part of the fusion of the horizons (Flood, 2010). I was also subject to a peer review by my supervision team, who provided an independent view and external references. The research process developed my professional capacity and autonomy in taking initiative and being proactive.

4.11.4 Dependability as Compared with Reliability

Reliability in qualitative research may be defined as the repeatability of the observations, while validity means the findings were accurately interpreted to reflect reality (Nieswiadomy, 1993; Schou *et al*., 2012). Each step of the data collection process was documented in a systematic way and with a logical connection. The researcher saw the presented experience from the eyes of the person who has lived that experience (Nieswiadomy, 1993). I therefore conducted all interviews using a phenomenologically consistent approach.

4.11.5 Conformability as Compared with Objectivity

Objectivity refers to the quality of being true without bias (Denzin and Lincoln, 2003; Creswell, 2003; Offredy and Vickers, 2010). The rigour and objectivity of the method imply the generalisability of results in quantitative research and the relevance of the findings in qualitative research. That the researcher described their prejudice of understanding is important to the interpretation of findings. There are references to theorists such as the Gadamer hermeneutic phenomenology, the van Manen method, and the Buddhist coping theory that inspired the analysis. Each situation and each story is unique. Multiple sources of data were used to make sense of the data. I described in detail the process of data collection in my field notes and conducted a two-layered data analysis accompanied by supporting documents. The findings are credible in that the participant's quotation is reasonable in terms of supporting the interpretation.

4.12 Chapter Summary

This hermeneutic phenomenological approach aimed to provide an in-depth understanding of participant's lived experiences. The research design shows the strategics of data collection including assessment, recruitment, sampling, data collection, and data analysis. Ten women with breast cancer who engaged in the practice of Buddhism were recruited with variations in their survival time ranging from three years to 30 years. Interviews took place in natural settings in the community, often via home visits, and were nondirective in nature. The study analysis and findings are now presented in the following chapter.

Chapter 5 Analysis and Findings

5.0 Introduction

This chapter presents the participant demographics and two tables summarising the findings of the 20 interviews, including their locations, duration, and the years of diagnosis and survivorship of breast cancer. Furthermore, it introduces the participants who received the treatment regimens and their family histories.

In this chapter, the study findings are reported in two sections, as follows:

> Section 1 includes both a thematic map and a table for each participant, along with verbatim quotes extracted from their data according to the van Manen method. Themes are identified from each participant's individual dataset in order for unique experiences or saliency to be highlighted.
>
> In Section 2, the participants' lived experiences are examined and a thematic map is provided to report a synthesis of shared experiences under the identified theme categories.

5.1 Quotes from Gadamer: The 'Lifeworld'

"In fact, history does not belong to us; we belong to it.

Long before we understand ourselves

through the process of self-examination,

we understand ourselves in a self-evident way

in the family, society, and state in which we live.

The focus of subjectivity is a distorting mirror.

The self-awareness of the individual is only a flicking

in the close circuits of historical life.

That is why the prejudices of the individual,

far more than his judgments,

constitute the historical reality of his being."

Gadamer, H-G (1994) pp.276–277

5.2 Participant Demographics

The 10 participants included in this study were all Chinese females who had received a clinically confirmed diagnosis of breast cancer. Their ages at the time of interview ranged from 41 years to 80 years, and the mean age of the 10 participants was 60 years. The length of survivorship experienced post diagnosis ranged from three years to 35 years. The participants reported it had been an average of 13 years since breast cancer diagnosis. Eight women underwent mastectomy, while two (Chloe and Jane) had undergone lumpectomy and two (Fanny and Helen) had undergone breast reconstruction surgery concurrently. Two participants (Betty and Helen) continued to use Chinese medicine after undergoing chemotherapy. Elsa was clinically diagnosed twice over a period of approximately 24 years (in 1989 and 2013), undergoing surgery, radiotherapy, and hormonal therapy on both occasions. All 10 participants were married with children, though one (Dora) had been widowed prior to her cancer diagnosis. The two youngest participants, Helen and Jane, were 41 years and 46 years of age, respectively, and had school-aged children. The other eight participants' children were all adults in full-time employment. All of them reported positive relationships with their husbands. Five participants (Amy, Chloe, Dora, Elsa, and Fanny) lived in privately-owned accommodations, while the other five participants (Betty, Gloria, Helen, Iris, and Jane) lived in rented public housing, reflecting the disparity in their economic conditions. In terms of employment, nine participants were housewives and three (Dora, Elsa and Iris) had retired after receiving their breast cancer diagnosis. Out of all of the participants, only Fanny had full-time employment (in an insurance agency and teaching in a tutorial centre). The participant details and interview data are presented in Tables 4 and 5.

Table 4: Demographic Findings

Pseudonym of Participant	**Age**	**Year of Dx./ No. Of Sur. Years**	**Surgery/ Therapy/ Private or Govt.**	**Marital Status/ No. of Children**	**Buddhist Practice**
1. Amy	61	2011/ 4	M, Ch, LN, T, R, H, Government	Married/ 3	SGI
2. Betty	63	2011/ 4	M, Ch, R, Private & Government	Married/ 4	Self
3. Chloe	54	2012/ 3	L, Ch, R, Government	Married/ 2	SGI
4. Dora	64	2010/ 5	M, LN, Ch, T, R, Private & Government	Widow/ 2	FGS
5. Elsa	80	1989/ 26, 2013/2	M, LN, R, H, Private & Government	Married/ 4	SGI
6. Fanny	57	1995/ 20	M, BR, R, Ch, Government	Married/ 2	SGI
7. Gloria	69	1980/ 35	M, LN, R, Private & Government	Married/ 1	SGI
8. Helen	41	2012/ 3	M, LN, BR, Ch, T, H, Government	Married/ 4	SGI
9. Iris	66	1998/ 17	M, Ch., Private & Government	Married/ 3	FGS
10. Jane	46	2006/ 10	L, LN, Ch, R Government	Married/ 2	FGS

M: Total Mastectomy, L: Lumpectomy, LN: Lymph node excision, Ch: Chemotherapy, T: Targeted chemotherapy, R: Radiotherapy, BR: Breast Reconstruction, H: Hormonal therapy, Buddhist practice: SGI: Soka Gakkai International, FGS: Fo Guang Shan.

Table 5: Interviews

Pseudonym of Participant and Location of First/Second Interview	Time Period between First and Second Interviews and Date and Duration of Each Interview
P1: Amy (Alliance International Education/Home)	Paced over 4 weeks 1. 30/7/2015 = 43 minutes 2. 23/8/2015 = 36 minutes
P2: Betty (TSA: Tai Shan Association/TSA)	Paced over 4 weeks 1. 8/8/2015 = 32 minutes 2. 2/9/2015 = 41 minutes
P3: Chloe (Alliance International Education/AIE)	Paced over 5 weeks 1. 19/10/2015 = 53 minutes 2. 23/11/2015 = 51 minutes
P4: Dora (Alliance International Education/AIE)	Paced over 5 weeks 1. 19/10/2015 = 47 minutes 2. 24/11/2015 = 59 minutes
P5: Elsa (Home/Home)	Paced over 5 weeks 1. 20/10/2015 = 52 minutes 2. 25/11/2015 = 40 minutes
P6: Fanny (Participant's Office /Office)	Paced over 5 weeks 1. 21/10/2015 = 54 minutes 2. 26/11/2015 = 70 minutes
P7: Gloria (Home/Home)	Paced over 6 weeks 1. 27/11/2015 = 48 minutes 2. 9/1/2016 = 56 minutes
P8: Helen (Home/Home)	Paced over 6 weeks 1. 28/11/2015 = 45 minutes 2. 9/1/2016 = 46 minutes
P9: Iris (Alliance International Education/AIE)	Paced over 4 weeks 1. 7/12/2015 = 54 minutes 2. 4/1/2016 = 64 minutes
P10: Jane (Fo Guang Shan/FGS)	Paced over 1 week 1. 7/9/2016 = 64 minutes 2. 14/9/2016 = 55 minutes

5.3 Section 1: Participants’ Thematic Maps and Unique Experiences

Section 1 presents the thematic maps for each participant to illustrate the themes and supporting subthemes identified from the thematic and van Manen data analyses. Each woman's testimony is supported with verbatim quotes extracted from their data.

This sections contains a number of tables used to summarise the themes identified from each participant’s individual data set, according to van Manen’s (1990, 2014) approach to hermeneutic phenomenology.

Table 6: Amy's (Participant 1) Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Amy Age at interview: 61 years Age at diagnosis: 57 years Being: *1. I have to maintain hope* *2. I should be optimistic and positive* Being-with-others: *1. I realised so many people were very nice and caring to me* Being-in-the-world: *1. I gave my life to Buddha and I was confident that I could handle*	Theme 1: *The chemotherapy side effects were severe* Theme 2: *I felt people around [me] encouraged me* Theme 3: *I had my religious faith to support me*	The Lived Space: *1. I remained at home in order to rest and prevent infection.* The Lived Body: *1. This would enable my body to become stronger.* The Lived Time: *1. I chanted once I was free* *2. Despite the difficult moments, I had my religious faith to support me* The Lived Relation: *1. I impressed others by changing my behaviour* *2. Believing in Buddha made a significant difference [in] my life compared to before*	Even though Amy was 'in infection control isolation' during chemotherapy, she had the safe feeling of 'being-at-home'. She was dwelling in the present moment to maintain hope because for her chanting was a sacred experience in a temporary way and provided a sense of peace for her.

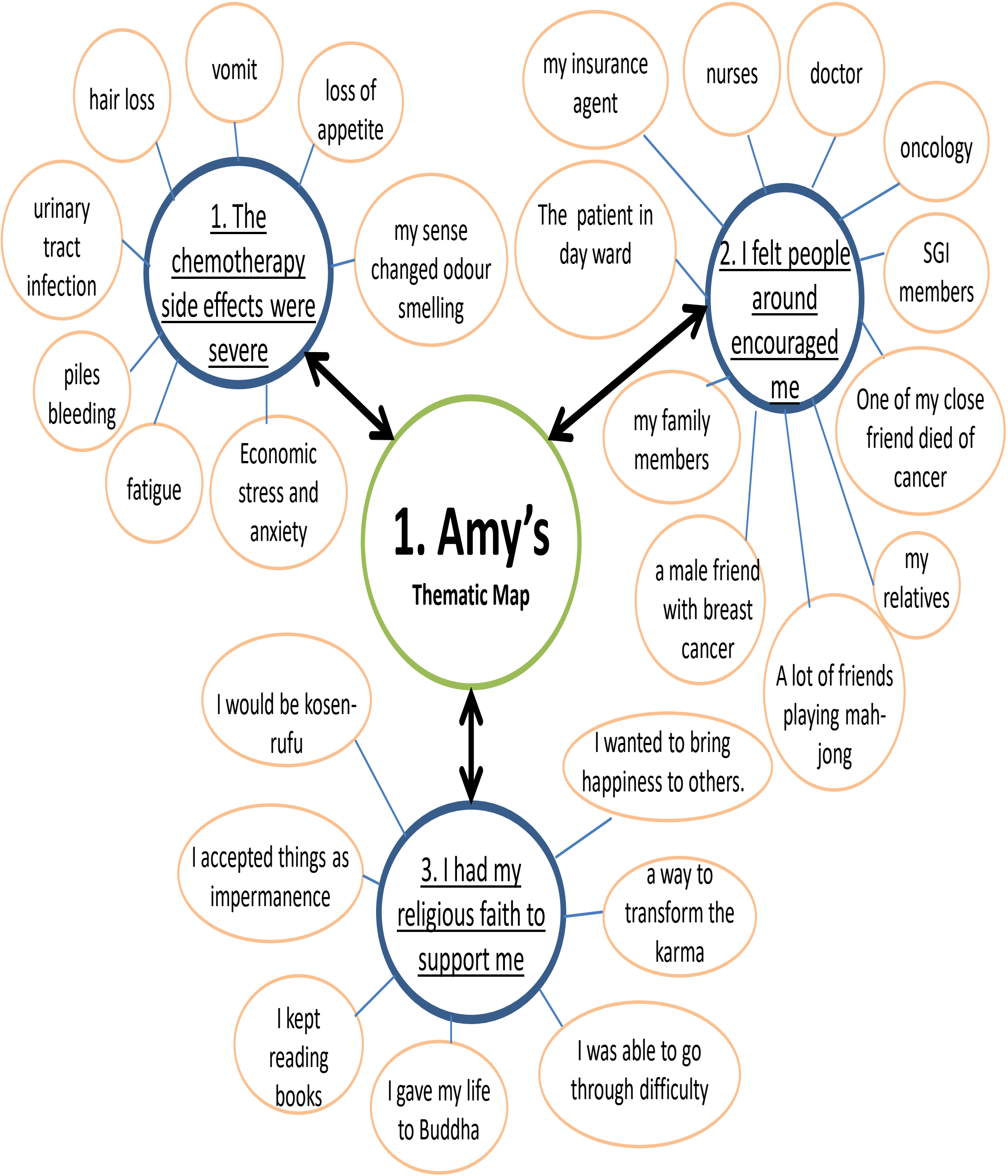

1. Amy's
Thematic Map
1. The chemotherapy side effects were severe
hair loss
vomit
loss of appetite
urinary tract infection
my sense changed odour smelling
piles bleeding
fatigue
Economic stress and anxiety
2. I felt people around encouraged me
my insurance agent
nurses
doctor
oncology
SGI members
The patient in day ward
One of my close friend died of cancer
my family members
a male friend with breast cancer
my relatives
A lot of friends playing mah-jong
3. I had my religious faith to support me
I would be kosen-rufu
I wanted to bring happiness to others.
I accepted things as impermanence
a way to transform the karma
I kept reading books
I gave my life to Buddha
I was able to go through difficulty

Figure 1: Amy

5.3.1 Amy

Before Amy received a diagnosis of breast cancer, she had believed in Nichiren Buddhism from a young age. Cancer can provoke prolonged psychological distress and physical suffering. Denial was her first response, forcing her to ask, ‘Why me?’ Her second response was negative thoughts and emotions, such as the fear of metastasis and death.

> *When the doctor informed me of the bad news that I had breast cancer, I cried instantly and asked, "Why me?”*
> (1/1/29) (Participant/Interview/Paragraph)
>
> *I had the strong sense of fear after I learnt of the disease. My understanding about cancer was that it would definitely lead to death.* (1/2/151)

Many breast cancer patients express anxiety about the uncertainty of treatment success and/or the recurrence of cancer (Nelson, 1996; Kim *et al*., 2011; Cheng *et al*., 2016). Amy was urged to undergo a quick operation; however, there was a shortage of beds in both public and private hospitals. At the time, in 2011, many illegal immigrants were giving birth to babies in Hong Kong. Consequently, she eventually chose to have a total mastectomy performed in a public hospital.

1. *The chemotherapy side effects were severe*

Amy reported chemotherapy as being particularly difficult, largely because of nausea and vomiting. Amy also experienced an altered body image because the chemotherapy made her bald.

> *The chemotherapy side effects were severe, and I suffered a lot. It included vomiting, hair loss, and a loss of appetite.*
> (1/1/95)

Amy also worried about the financial burden of her illness on her family:

> *At that critical phrase, the medical expenditure was very...very high...I was very lucky. I had believed in a religious faith, and I bought the insurance plan of critical illness two years before.*
> (1/1/76, 1/1/78)

She believed that her religious faith supported her and protected her in the treatment and the recovery process. She was feeling grateful and appreciated the *Gohonzon* arrangement; as such, she was very fortunate to have received insurance compensation from the critical disease plan, which was several tens of thousands of US dollars. The lived time focused on finishing the treatments.

> *I simply hoped that the treatments of six chemotherapies, 18 targeted therapies, and 16 radiotherapies would be completed as soon as possible.*
> (1/1/77)
>
> *In spite of the difficult moment, I had a religious faith to support me. Okay! Let it be!*
> (1/1/31)

Amy changed gradually, shifting from denial to acceptance through religious coping reappraisals.

2. *I felt people around [me] encouraged me*

Amy reported that she mainly stayed at home during chemotherapy treatment to minimize the risk of infection. Once treatment was completed, she became more active in social circles, such as by playing mahjong:

> *After the mahjong gathering with my friends, I went home. I was a good patient [in] that I stayed at home to take a rest in order to prevent infection. I ensured [that I was] having sufficient rest.*
> (1/1/130)

There is a significance in playing mahjong in Chinese culture. Mahjong provides a sense of community social support, offering a space and time to ventilate personal feeling with friends. Notwithstanding, the use of mahjong in this context might be culturally specific to Chinese and might not be applicable to people of other cultures. In this case, Amy had awareness and maintained a balanced attitude of play and rest moments. Amy demonstrated gratitude to being-with-others; many people helped her during the most difficult period of her cancer journey.

> *During the sickness period, lots of SGI members visited me and arranged gatherings for chanting. I felt that people around [me] encouraged me.*
> (1/2/62)

Family and social support and increased religious practices play a significant role in emotional support in breast cancer survivorship (Al-Azri *et al*., 2013).

3. *I had my religious faith to support me*

Amy described how, during this time, her sacred religious experiences contributed to transforming her karma.

> *After I learnt of Buddha's teaching, I was aware that humankind had 'karma'. Nobody knew when it came. Once it appeared, we had to confront*

> *it with ease. We would not grumble … From the perspective of Buddha’s teaching, life is eternal. The body of this life cycle will be different from the body of the next cycle. However, the life will still exist. If you accumulate ‘fortune’ in this life cycle, you will be born in a place with Buddha’s teaching or a good place during the next life cycle.*
> (1/2/77, 1/2/111)

Transformation means to have changed our karma. We do not know our karmic history, and we do not know the effects we have to face from causes we made in past lives. All we know is that the law of cause and effect is at work and whatever challenges we face are a direct result of the karmic choices we made in the past.

Amy had a unique perspective on karma as to how it affected her actions and life after death. Her existential meaning of life was inspired by Buddhism and involved believing that she would be born into succeeding life cycles. Amy believed that chanting was a method of opening up her own innate Buddhahood.

> *Chanting a specific theme … granted wisdom and brought communication with Buddha. The unresolved problem would be solved by means of chanting... My mind was peaceful and in comfort as I perceived that I had earned a new day when I woke up in the morning. I thought I had to do well to ensure I had good results in the future.*
> (1/2/19, 1/2/81)

Chanting while facing the Gohonzon was a special time for Amy; it granted her wisdom and brought communication with the Buddha. Amy said that this wisdom kept her focused on other people's happiness; therefore, she was not focusing on her own illness or suffering. She spent around half an hour chanting and tried to chant during her recovery journey. She expressed the *Nam-myoho-renge-kyo* through chanting to gain power back in her life, especially when facing difficulties or suffering. Whenever she was in high spirits, she chanted for longer.

> *At first, I felt embarrassed talking about breast cancer. At present, I did not mind sharing the experience of having breast cancer with others … I gave my life to Buddha and I was confident that I could handle [it] … I impressed others by changing my behaviour. Believing in Buddha made a significant difference from before. They were convinced of 'Kosen-rufu' … I have to maintain hope … I should be optimistic and positive.*
> (1/1/189, 1/1/201, 1/2/13, 1/1/114)

Understanding her place in the world provided her with meaning, which was apparent in her account of outward hope expressing eternal life. An individual's acceptance of their disease revolves around positive thinking, rather than passive avoidance. Buddhists consider stress as a form of karma and *dukkha* (Sanskrit: *duhkha* or suffering), which is an inevitable part of the human existence (Tyson and Pongruengphant, 2007; Phillips *et al*., 2012). *Dukkha* means suffering, pain or sorrow; as opposed to the word *sukha*, meaning happiness and comfort (Rahula, 1958; Tyson and Pongruengphant, 2007). Life and death are just like springtime after winter (Pesek *et al*., 2010). If people do not die in the winter climate (i.e., overcome a lot of suffering), they can enjoy the spring sunshine time (i.e., recovery). Amy found that her faith led her to happiness and to have a meaningful life. She strived to adapt and, further, to redefine her life. Several Buddhist coping strategies can be identified in her existential essence, including positive cognitive restructuring, wishful thinking, increased religious practices, and encouragement by family and social supports. Her life mission was continuous studying of the teachings of Nichiren and she sought to increase her participation in the *Kosen-rufu* to promote the Lotus Sutra.

Table 7: Betty's (Participant 2) Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Betty Age at interview: 63 years Age at diagnosis: 59 years Being: *1. I was very scared and felt helpless. (treatment)* *2. I was really delighted and grateful during this time (four years later)* Being-with-others: *1. I made plenty of good friends* Being-in-the-world: *1. I intended to do voluntary work to help others*	Theme 1: *The suffering was overwhelming* Theme 2: *I felt glad and grateful* Theme 3: *I felt peace and comfort after chanting*	The Lived Space: *1. I myself relied on my religion* *2. I was in high spirits* The Lived Body: *1. I suffered from mouth ulcers* *2. My ear 'hurt' to the extent that I always heard a "buzzing" sound (tinnitus)* The Lived Time: *1. I suffered significant pain over time* *2. I do not have positive memories of that time* The Lived Relation: *1. It was because many of my friends offered so much assistance* *2. I performed voluntary work when I had free time*	Betty was in high spirits because she enjoyed the spatial-dwelling with the singing and exercise activities that could build a happy relationship with others. All of her painful body experiences were forgotten and she focused her happy mood on being caring and respectful in this situation, as if it was an adventure into new landscapes in the Tai Shan Charitable Association.

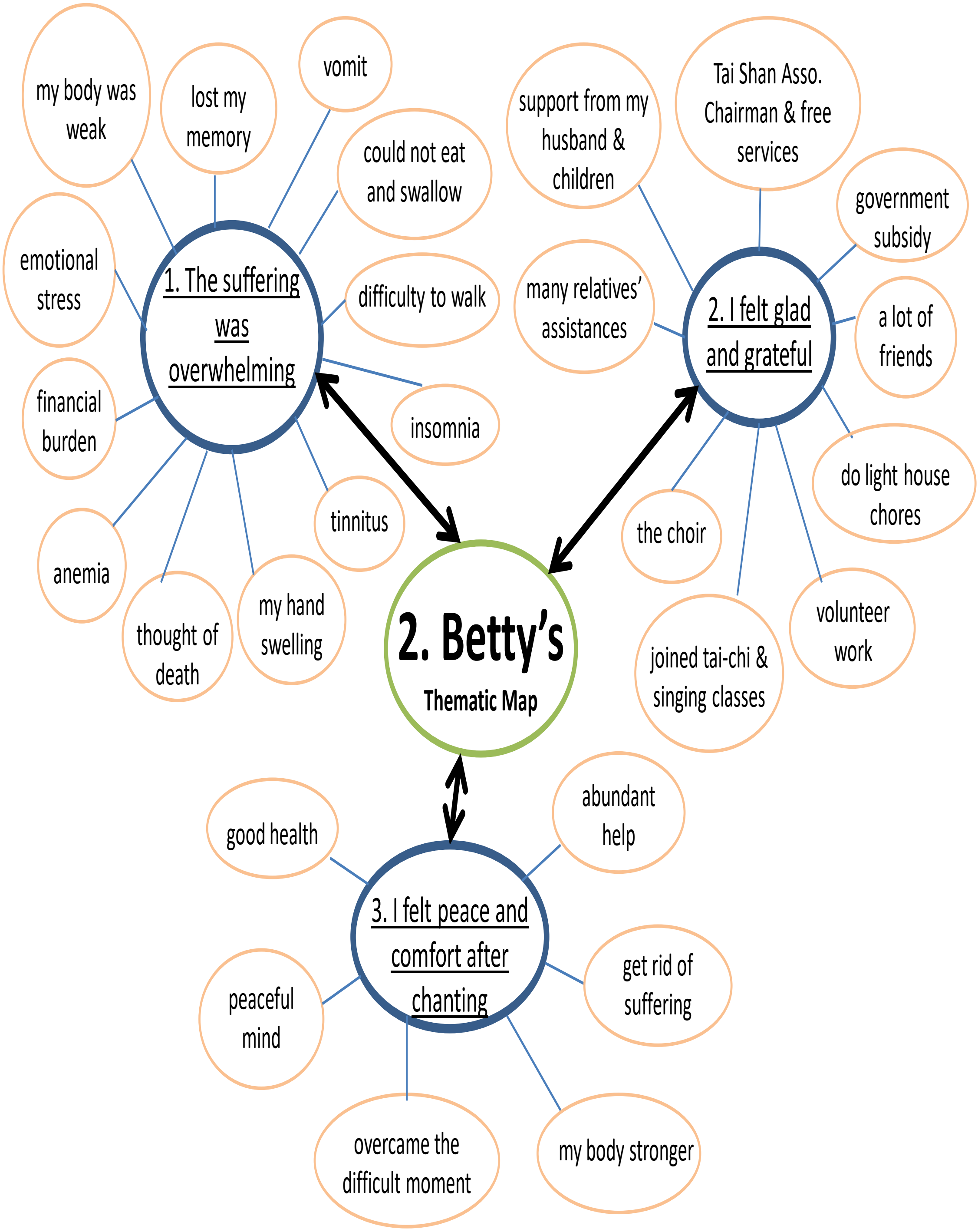


Figure 2: Betty

5.3.2 Betty

At the time of the interview, Betty was a housewife aged 63 years and had four children. She had developed breast cancer approximately four years previously and underwent chemotherapy, radiotherapy, and targeted therapy at a government hospital.

1. *The suffering was overwhelming*

Betty was significantly worried about the financial burden her illness and treatment would cause, owing to her poor economic situation. The side effects of the chemotherapy were so severe that they drastically weakened her lived body.

> *I was very scared and felt helpless … I stayed at [the] hospital because I was unable to walk and I also lost my memory. I could not even recognise my husband, children, or anybody else. The side effects of the drug were so serious that it had weakened my body drastically ...The greatest stress came from the loss of sleep. I suffered from insomnia for half a year. I felt pain in my ear, in the sense that I always heard a 'buzzing' sound (tinnitus). This caused huge annoyance to me and disturbed my sleep. As I could not walk, I was deeply concerned that I was becoming a huge burden for my family ... It seemed I was incapable. Resultantly, I thought of death.*
> (2/2/8, 2/1/15, 2/1/64, 2/1/30)

Betty's self-awareness was an important difference from the other participants regarding their responses to suffering. The primary source of her stress came from her suffering, insomnia, and the sense of being a family burden. She hardly had any strength to walk and felt too fatigued to carry anything. Her loss of memory had a significant negative impact on her daily QOL. The literature seldom addresses how patients interpret "chemobrain" experiences for themselves, such as perceptions and cognitive impairment, which are not acknowledged by health care professionals (Mitchell and Turton, 2011). Betty might have an impaired sense of identity. Her feeling of helplessness were the result of her being incapable of performing her basic daily activities. Fear and perception of risk can lead women to explore complementary and alternative medicine (CAM) (Mitchell and McClean, 2014). Betty searched for CAM treatment in the form of Chinese medicine in the Kwong Wah Hospital in 2015.

> *I could recover swiftly with the assistance of Chinese medicine. I [underwent a] consultation for more than one year. I found that it was very useful indeed. I felt that my body was much stronger than before.*
> (2/2/145)

Betty had a unique positive experience of receiving Chinese medicine.

2. *I felt glad and grateful*

Betty felt grateful for being-with-others, such as her peer group, which enabled her to make the positive transition from patient to survivor. She has subsequently performed regular volunteer work to give moral support to other cancer patients through the TSCA. This helped to shift her from her sense of helplessness into a state where she could help others. Betty has transitioned into a life of service, and discovered new meaning in her life in the process.

> *I joined tai-chi shibashi [Tai-chi exercise] and singing classes organised by the Tai Shan Charitable Association … After I recovered, I intended to do voluntary work to help others ...These are joyful moments and we have the opportunity to chat with others.*
> (2/1/51, 2/2/88, 2/2/130)

Coping with cancer stress involves surveying the situation, taking action, and emerging in the self, which is an ongoing personal growth process (Lally and Underhill, 2012). Betty's practices, such as meditation and exercise, have been shown to enhance vitality. Singing and exercise can promote physical and psychosocial wellbeing and longevity (Pesek *et al*., 2010).

3. *I felt peace and comfort after chanting*

Betty was the only participant who did not join any Buddhist organisation. Her self-practice focused on Guan Yin Bodhisattva and Buddha, as well as chanting the life-extending 10-line Kannon Sutra. Her lived time was transformed after chanting.

> *I frequently recited 'Guan Yin Sutra' to make my mind peaceful and calm. When chanting, I felt calm and peaceful. Sometimes, I suffered from loss of sleep. I spent the time chanting. I became happy after chanting. Before I had the disease, I dared not think of the word 'death'. After I contracted the disease, I changed my mind. I thought 'life was impermanent'. I did not place too much focus on life and death. I took it easy. I learnt a lot. I made plenty of good friends ... I was really delighted and grateful during this time … I received assistance from many of my relatives ... I avowed that I would help my husband and children after my recovery. I could take care of them for a longer time. I hoped that my life could be sustained longer. Gradually, my body recovered and strengthened.*
> (2/1/77, 2/2/8, 2/1/47, 2/2/71)

Maintaining normality and continuing the mother role are important in survivorship (Fisher and O'Connor, 2012). Betty intended to fulfil her maternal role, and therefore prayed for health and longevity.

Table 8: Chloe's (Participant 3) Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Chloe Age at interview: 54 years Age at diagnosis: 51 years Being: *1. I was a timid person* *2. I used to be stubborn and firm* *3. I was very subjective (past)* *4. I am more pleasant (now)* Being-with-others: *1. I had the feeling that other patients and I were companions as we encountered similar experiences* Being-in-the-world: *1. In SGI, I belonged to a group responsible for making costumes for the SGI members or SGI kindergarten graduates [for their performances] on stage*	Theme 1: *The suffering was rather baffling* Theme 2: *I did not let others know* Theme 3: *I chanted every time I experienced problems* *Theme 4:* *I changed myself*	The Lived Space: *1. Life is bitter* *2. You devise methods to make it sweet* The Lived Body: *1. All the bones in my body were so painful* *2. I was very itchy over every single part of my whole body* The Lived Time: *1. I experienced a very hard time* *The Lived Relation:* *1. I did not let others know, including my friends [and] younger brothers and sisters (past)* *2. In the patient support group, we shared the same feelings and showed mutual concern to each other* *3. Our relationship was closer than with our old friends (now)*	Chloe enjoyed being alone in the treatment period because she felt that other people focused on her appearance and body and neglected her emotional or spiritual wellbeing. Chloe kept on chanting to change her negative karma. Even though she was alone, the meaning of chanting constituted a positive and optimistic space and a time spent at home.

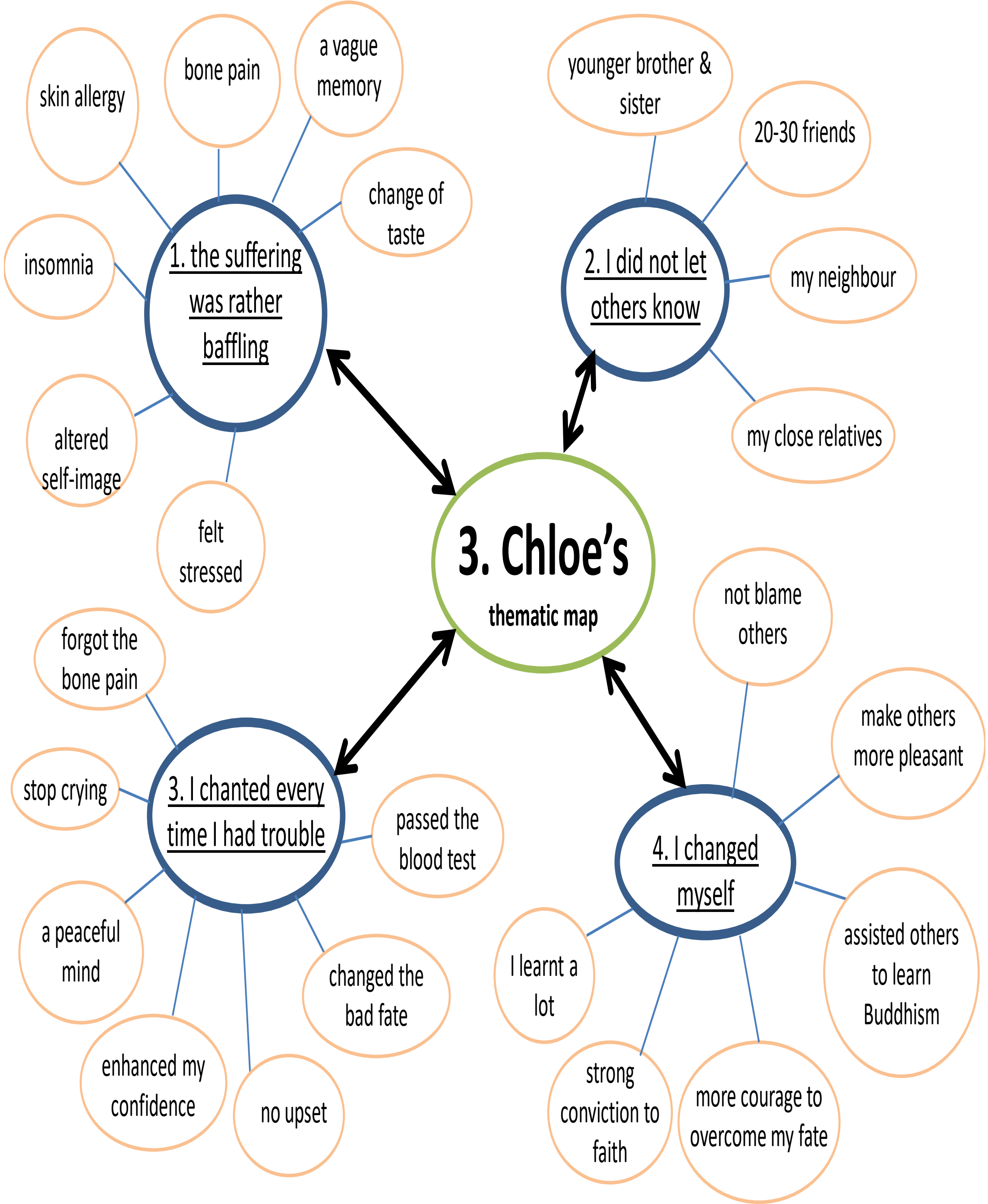


Figure 3: Chloe

5.3.3 Chloe

Chloe’s breast cancer was triple-negative, meaning that neither estrogen receptor (ER), progesterone receptor (PgR) nor human epidermal growth factor receptor 2 (HER2) were effective in curing the disease by hormonal therapy or anti-HER2 therapy. Although her breast cancer was in stage 1 and the right sentinel lymph nodes were not affected, she felt a lot of uncertainty and anxiety during and after her partial lumpectomy surgery.

1. *The suffering was rather baffling*

Chloe’s suffering came from her lived body experiences after the chemotherapy treatment, including Filgrastim injections to treat neutropenia in the following six examples.

1. Bone pain

> *The bones of my whole body were so painful that I could not either sit or lay down … The suffering was rather baffling ... I had to be tough and could not be weak. I went through with a hard time.*
> (3/1/18, 3/1/29, 3/1/32)

2. A vague memory

> *I had a vague memory about the details. It seemed that I underwent radiotherapy every day. I did not remember clearly.*
> (3/1/36)

3. Taste change

> *I ate vegetables without adding any salt. However, it tasted extremely bitter.*
> (3/1/39)

4. Skin allergy

> *However, they were intolerably itchy. It even affected my throat and I almost could not breathe properly ... the most serious suffering came from skin allergy ...my whole body was very itchy. The rash was dark grey … It was very itchy, which I was unable to describe concretely. I was very itchy for every single part of my whole body. I scratched so much that every part of my body swelled*.
> (3/1/42, 3/1/51)

5. Insomnia

> *However, I suffered a lot. I could not sleep. I suffered seriously when I laid down. The suffering was rather baffling.*
> (3/1/29)

6. Altered self-image

> *My appearance looked scary during the days the chemotherapy drug was injected. I suffered loss of eyebrow and my eyes were yellowish. I could hardly accept this change.*
> (3/1/76)

Merleau-Ponty (1962, p.82) stated, ‘the body is the vehicle of being in the world’. Chloe’s being-in-the-world was characterized by her lived body being full of pain, itchiness, and suffering. This is a good example of a breast cancer patient explaining how lived experiences altered their lived world. She felt very fragile and even slipped and fell. Even though Chloe suffered a lot of side effects during chemotherapy, she was determined never to give up.

2. *I did not let others know*

Chloe experienced social distress and hoped to maintain her sense of personal privacy. Chloe concealed her condition and enjoyed being alone.

> *I did not let others know, including my friends [and] younger brothers and younger sisters ... There were too many friends asking me repeatedly. I did*

> *not intend to repeat the answers again and again. While I was trying to forget about the illness, the friends kept reminding me of it by asking repeated questions. I felt stressed. I felt more relaxed if others did not know about this. Even when I wore the wig, I denied having an illness in response to others' queries. I thought this made me comfortable. The most difficult aspects were that I had to wear a wig, creating a different appearance, and losing the sense of taste ... My appearance looked scary on the days on which the chemotherapy drug was injected. I suffered the loss of my eyebrows and my eyes were yellowish. I found it difficult to accept this change.*
> (3/1/63, 3/1/73, 3/1/76)

The evaluation of stress was highly subjective. Being the centre of attention prompted a different interpretation of the situation. Chloe felt that other people focused on her appearance, which caused anxiety and loneliness. In response to these feelings, women with breast cancer in some research studies reportedly used emotional coping methods such as distancing, self-controlling, and escape-avoidance (Boehmke & Dickerson, 2006; De Vries *et al*., 2014).

3. *I chanted every time I had trouble*

Chloe continued to chant the Nam-myoho-renge-kyo, which infused her with enthusiasm and energy.

> *I used to be stubborn and firm. I was very subjective ... I had changed my character, but I was not aware of the difference ... I felt happier. My sickness made me feel the strength of the teachings of Buddha ... After experiencing so many challenges, I could definitely feel the power of 'Nam-myoho-renge-kyo'. I had a peaceful mind to accept the arrangement of 'Gohonzon'...I chanted 'Nam-myoho-renge-kyo' very hard. This would change the fate of this life. The fate of the new life would be better.*
> (3/2/17, 3/2/12, 3/2/8, 3/2/10, 3/2/27)

After receiving her cancer diagnosis, Chloe observed that her character was transformed from being a subjective person to being caring and compassionate about other people's feelings.

4. *I changed myself*

Chloe accepted her survivor identity and she found her life's meaning in a patient support group.

> *I shared my difficulties with the other patients. We helped each other in times of need. I occasionally accompanied other patients when walking around. I underwent the treatment process of chemotherapy with mutual support ... We expressed concern to each other. It seemed as though they were my relatives. We felt each other's suffering... We shared our suffering and gave suggestions to each other on how to solve the problems ... I should learn to tolerate others and understand others' difficulties.*
> (3/1/29, 3/1/42, 3/2/22)

Chloe frequently visited the hospital and developed an impulse to help others. Once Chloe entered the hospital, she experienced a sense of companionship with other patients, as they had encountered similar experiences. Her coping strategy evolved in a more problem-solving direction. Her faith in Nichiren Buddhism provided her with the confidence necessary to transform her situation, to become stronger, and to overcome the challenges she encountered. Chloe felt that her illness had a special meaning, which encouraged her to continue studying and practising Nichiren Buddhism. Part of her change was a significant transition to focus on the present moment, rather than on the perceived amount of time left or on the anticipated future. She experienced enjoyment while chanting with the belief that her fate would improve.

Table 9: Dora's (Participant 4) Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Dora Age at interview: 64 years Age at diagnosis: 57 years Being: *1. I was quite stubborn* *2. I was an optimistic person* Being-with-others: *1. I realized that others showed great concern to me* *2. Without this illness, I would not have noticed the love of so many people* Being-in-the-world: *1. I hoped I could raise my children* *2. I was capable of offering assistance to others*	Theme 1: *I overcame the difficulties* Theme 2: *I had a hard time* Theme 3: *I am a Buddhist*	The Lived Space: *1. I realised that friends and relatives were truly concerned for, and supportive of, me* The Lived Body: *1. My left breast was removed* *2. My body was weak* The Lived Time: *1. To my mind, it was the hardest time* *2. The harder times we had encountered, the tougher we would be* The Lived Relation: *1. I had duties in my Buddhist organisations* *2. My senior brothers and sisters and masters were supportive of me*	Dora had gradually grown into a state of well-being with social support to cope with the sudden death of her husband. She found the most profound effect in present-centeredness dwelling. She also enjoyed her kinship and belonging in a Buddhist organisation. During the protective chanting along with the Buddhist monks and nuns, she felt herself being cleansed of negative karma through problem-solving action.

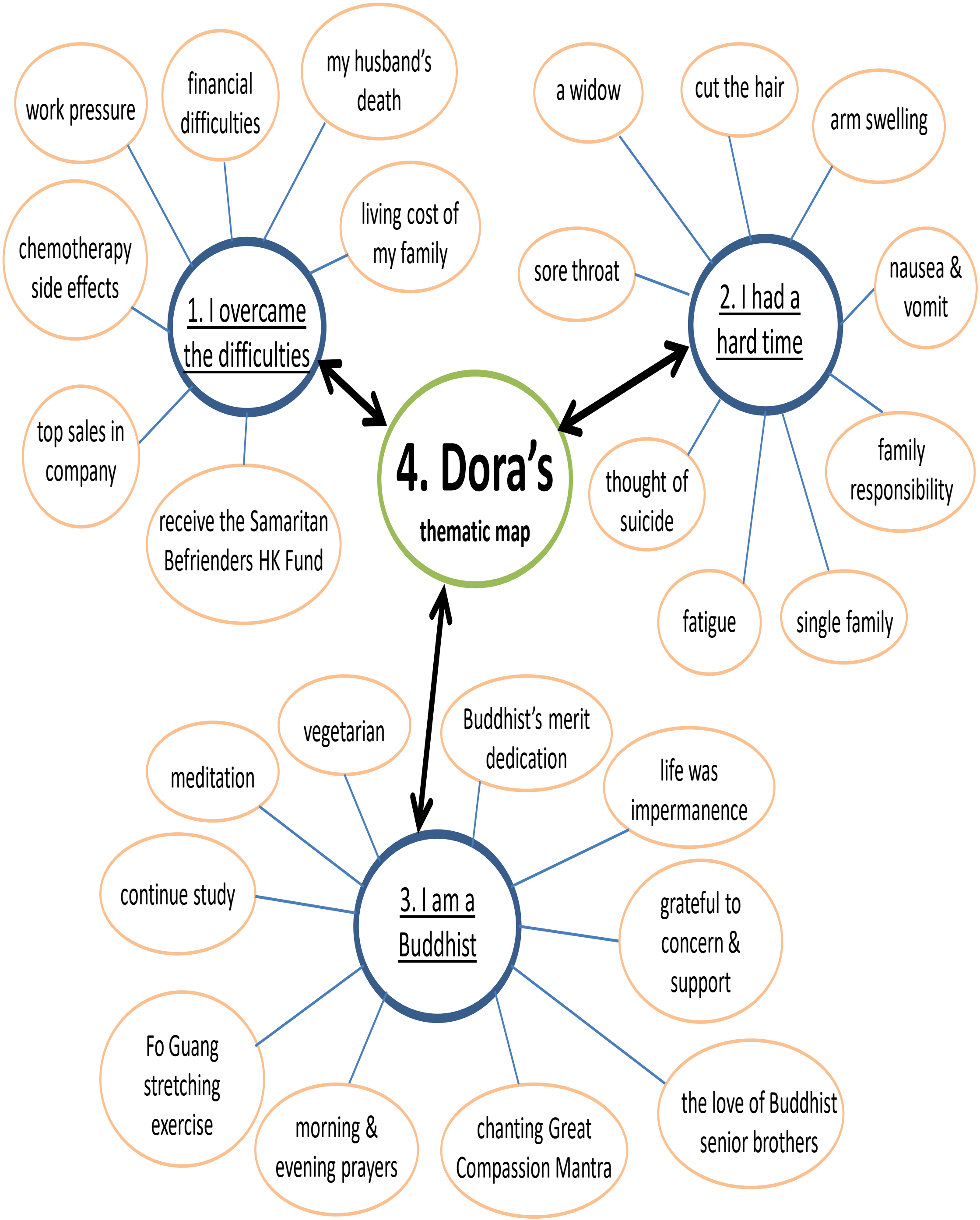


Figure 4: Dora

5.3.4 Dora

Dora worked as a clerk in a hardware factory and retired in 2010 because of her diagnosis of stage 2 breast cancer. She had undergone total abdominal hysterectomy and bilateral salpingo-oophorectomy at the age of 45 years, after which she took four years of hormonal replacement medications. She expressed that the pressure of work was great. She had had a mastectomy and also had nine lymph nodes resected in a private hospital.

1. *I overcame the difficulties*

Dora's stress came from the financial factor, as her medical expenses had been partially paid by her company's insurance.

> *The greatest stress came from the financial factor ... This was the only stress … I applied to 'The Samaritan Befrienders Hong Kong' to waive part of the costs … I did not want to add a burden to him (her son) … Nevertheless, the pressure of work was great … This has created huge pressure since that time only. I had been working since my children were small because I was the core financial support. I shouldered the responsibility. I had a job until I retired due to my sickness.*
> (4/1/75, 4/1/54, 4/1/82, 4/1/105, 4/1/96)

She experienced significant stress as a result of taking self-financed targeted therapy medications and suffered during both chemotherapy and targeted therapy. She was a widow and the sole breadwinner of her family. Monthly income is also a significant predictor of QOL in a cancer journey (Kim *et al*., 2011). Dora selected a problem-solving coping strategy to succeed in addressing her major life challenges.

2. *I had a hard time*

Dora described herself as a tough person.

> *I belonged to a single-parent family … My husband passed away more than 20 years ago. He died of a disease. At that time, my younger son was in Kindergarten 1 and my elder son was in Primary 5 … I overcame the difficulties because my husband loved me deeply. I loved my husband deeply too. I hoped I could raise my children … It was tough to withstand the pain.*
> (4/1/8, 4/1/92, 4/1/94)

She detailed how her personal experiences enabled her to perceive the world differently. When her husband died suddenly over 20 years ago, she accepted her fate and became enlightened to the concept that life was a form of karma and suffering (dukkha).

3. *I am a Buddhist*

The death of Dora's husband represented a turning point in her life.

> *I thought about committing suicide at the time my husband passed away … Just as the Buddha's teachings advised, 'Advantage from disadvantage', I considered this harsh treatment as a form of training for me so that I could sustain myself during the hardship … The harder times we had encountered, the more tough we would be … Within that year (chemo and target therapy) … I was a Buddhist … I was grateful that I had the disease. I realised that my friends and relatives were truly concerned and supportive of me. Without this illness, I would not have noticed the outpouring of love from so many people. Therefore, to a certain extent, there were positive aspects of having such a disease. I was happiest when I knew that plenty of my senior brothers and sisters and masters in my Buddhist organisation showed concern for me. My family showed great concern for me, including my relatives and my sons. I realised that my two sons were truly concerned for me … I had no regrets for this life.*

> (4/1/126, 4/1/109, 4/1/110, 4/1/61, 4/1/124)

Dora felt that the disease was an opportunity that opened the door for her to become a Buddhist. ‘Advantage from disadvantage’ is a Buddhist phrase meaning that adversity can be perceived as an opportunity for self-growth and development. Dora found her positive thinking could help to conquer her hopelessness and unhappiness. Dora focused on the meaning of present situations rather than her past memories of suffering. Dora believed that her motivation originated from her being a mother responsible for caring for a family.

Dora was the only participant who needed protein supplements during chemotherapy because she was a Buddhist and a vegetarian.

> *As I was a vegetarian and a Buddhist, I did not eat meat. I did not need to avoid certain foods in my diet … I learnt various forms of exercises such as stretching the arms or learning against the wall. This was to avoid varicose veins … I could not escape from ‘impermanence’ once it appeared, no matter what I did. I faced up to it joyfully. I did not query why I was the one with this fate and why I was the one who had cancer. I had never thought about this. I only focused on how to face up to it, how to solve the problem and act properly.*
> (4/1/48, 4/1/73, 4/2/12)

Dora adopted the problem-solving approach and developed a new normal life. Based on her belief in the Buddhist teachings, Dora became optimistic. She faced her responsibilities and had no regrets in her life. She is now actively contributing and serving others through FGS, her Buddhist organisation.

> *I hoped that, with the heart of mercy, I suffered pain for the sake of others so that they would not suffer pain during the surgery … Their blessing was that they had morning and evening prayers every day. During their prayers*

> *(FGS monks and members), they had dedication of merits. They would dedicate [prayers] to all the patients for speedy recovery and good health, including me.*
> (4/2/8, 4/2/17)

The Buddhist monks and patients often perform a religious ritual known as “protective chanting,” which is intended to provide blessings and ensure the survivor's happiness as well as their physical and psychological wellbeing (Kong, 2007). Dora chanted *Namo Avalokitesvara* in her mind and worshipped by protective chanting *Namo Amitabha*, which relieved her pain during an operation. Dora had also practiced the *loving-kindness meditation* and *compassion meditation* so that she became intended to suffer pain instead of the other patients. She created hope, developing a deep concern for other people and, because of these close interpersonal relationships and social activities, her sense of contentment in life increased. Dora’s was a heart of compassion, similar to that of a bodhisattva. Buddhists consider the self to be an illusion constructed in the mind (Tyson and Pongruengphant, 2007). The ego embeds attachments to the self, with these being considered among the major barriers to enlightenment (Tyson and Pongruengphant, 2007). That is why the Buddhist disciples encourage altruism.

Table 10: Elsa’s (Participant 5) Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Elsa Age at interview: 80 years Age at diagnosis: 55 years; recurrence at 78 years Being: *Being a traditional woman, I was stressed about my family* Being- with-others: *I even convinced others of my belief in Dharma and chanted for others* Being-in-the-world: *I hoped that I would give support to them through the strength of the ‘Gohonzon’*	Theme 1: *Why was there a recurrence?* Theme 2: *I also joined many SGI activities* Theme 3: *I was stressed about my family* Theme 4: *I believed in Gohonzon*	The Lived Space: *1. I believed in ‘Gohonzon’* *2. I did whatever I was capable of in SGI* The Lived Body: *1. The radiotherapy made my body dry* The Lived Time: *1. I did not suffer intensely at that time (55 years)* *2. It was difficult to find more time (30–55 years)* *3. During these 10 years (70–80 years), time was neither fast nor slow (5/2/28)* The Lived Relation: *1. I attended Guardian Club meetings of the SGI; I enjoyed those the most*	Elsa experienced a state of well-being in her dwelling in SGI volunteer work, which gave her a peaceful sense of ‘feeling at home’. Furthermore, her embodied domain- and identity-dwelling were focused at the present moment on caring for her family, who felt very comforted in their experiences and time passed swiftly

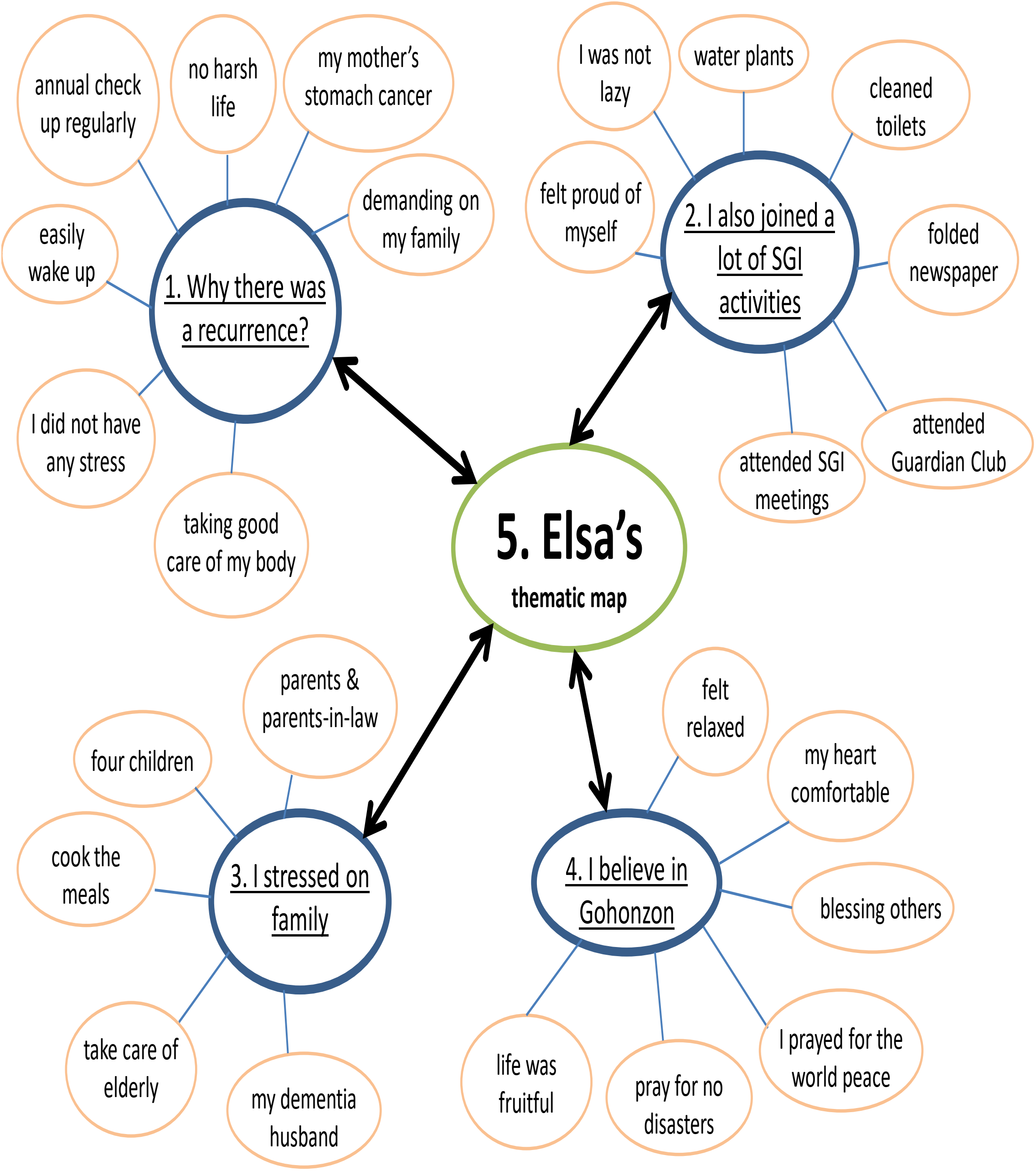


Figure 5: Elsa

5.3.5 Elsa

Elsa was the oldest participant (80 years) in this study; therefore, her interview was conducted in her home. She could not explain why there had been a recent recurrence of breast cancer after 25 years of remission. Elsa had delayed treatment for almost three years because her family doctor had advised her that the breast lump was benign. She could recall exactly that the first surgery had been performed on 9 December 1989 at the Tung Wah Eastern Hospital.

1. *Why there was a recurrence?*

Elsa had taken hormonal drugs nine years longer than any other participant. The hormone medication had caused her uterus to grow multiple polyps and she was ultimately required to have a hysterectomy. As the malignant tumours grew again, it provoked intense anxiety.

> *I thought that [because] my breasts were removed … the chance of recurrence should be low. I did not have any idea why there was a recurrence. In fact, it should not be considered as [a] recurrence, as it might be due to the growth of new cancerous cells. It was quite strange that, despite [the] removal of [my] left breast, a lump appeared again on my left side. I thought it was not cancerous.*
> (5/1/44)

Elsa's recent health problems have included hypertension and osteoporosis, induced by hormonal drugs. After having a recurrence of breast cancer, Elsa indicated that she did not feel as much suffering after chanting and, therefore, believed that Buddhism was protective.

Her primary lived body experience was dryness in the throat.

> *The radiotherapy made my body dry. I had to take some moistening drinks (e.g., siraitia grosvenorii), [drink] fruit juice, [and eat] boiled apples. Every time I had radiotherapy treatment, I brought a jar of this kind of drink with me. I did not suffer any pain … A nurse was very kind and advised me to lift the arms by combing hair or pulling things. She further advised me not to [consume] 'raw-fish soup'.*
> (5/2/8/10–13, 5/1/13)

Elsa was brave in recovery; she did not seek any counselling services from the patient support groups. The Hong Kong Cancer Fund and Hong Kong Breast Cancer Foundation had not been established at that time. She recalled that the hospital nurse was kind and had advised her not to eat 'raw-fish soup' and to regularly exercise her left arm. Professional culture is derived from beliefs and behavioural norms, which are socialised and reinforced by the core values common to nursing (de Viggiani, 2013). It is also a common Chinese cultural belief that 'raw-fish soup' is detrimental to wound healing.

2. *I also joined numerous SGI activities.*

Elsa became a member of Hong Kong SGI in 1987. The regular SGI meetings provided Elsa with confidence and mutual encouragement.

> *Every day I chanted, which made my mind clam and peaceful. The discussions of meetings and the speech of senior members of SGI seemed to [be targeted] at me and try to solve my problems. Thus, I was confident in meetings.*
> (5/1/42)
>
> *I also joined many activities, even though I had undergone surgery. I participated in the Guardian Club, watering plants, cleaning toilets, etc. I did not encounter any problems. During the period of surgery, I was not in any pain. I believe in 'Gohonzon'. It was deep in my heart. The other patients did not notice that I had undergone surgery. I even encouraged*

> *some patients to chant. I was full of confidence, [believing] that there were no problems ahead ... In SGI, I did whatever I was capable of ... I watered plants, cleaned toilets, folded newspapers, etc.*
> (5/2/11, 18, 22–23)

Her strong sense of belonging is her SGI member's identity. Even though she underwent a mastectomy, she worked as a volunteer in SGI, including doing activities such as cleaning toilets. By remaining active, this functioned as her protective shield, which allowed her to enjoy her new life, leading to personal growth and positive embodiment-dwelling.

3. *I stressed about my family*.

Elsa remained at home during her recovery in order to teach her children.

> *I had four children. I longed for getting a job and I had worked before. My husband was responsible for the economy of the family. I was not a lazy woman. In addition to taking care of my elderly parents, parents-in-law, and children, I spent time teaching [the] children to draw during Saturday. I felt proud of myself. It was because it was difficult to squeeze [in] more time. I had to attend meetings and lessons. Life was fruitful and normal. I did not play mahjong. I did not go to cinema. Besides giving drawing lessons to children during Saturdays and Sundays, I went to [the] kitchen to cook the meal after work. There was not much spare time for activities and entertainment. I attended meetings, folded newspapers, and attended Guardian Club meetings. These were [what] I enjoyed most.*
> (5/2/22)

Elsa also had concerns about her husband.

> *I heard from a seminar that he was suffering from the early stages of Alzheimer's disease. He did not need to take pills. He experienced a loss of memory. He could not remember the date and asked the same question*

> *frequently.*
> (5/1/86)

Thus, additionally, significant pressure arose due to her responsibility of caring for her husband with dementia. As Elsa's mood-dwelling perceived that her lived relation was her family, she prayed for the whole family's harmony and happiness. The concept of harmony originates from Chinese Confucianism, although a similar concept of benevolence and compassion is mentioned in Buddhist teachings (Simpson, 2005).

4. *I believe in Gohonzon*.

Elsa described her daily chanting practices and feelings.

> *After marriage, the core of my life was family. Being a traditional woman, I was stressed about my family. Empowered by Buddhist teachings, I prayed that every child would be healthy and happy. The whole family was in harmony and happiness … I hoped that I would give support to them through the strength of the 'Gohonzon'. Everyone was fine. The family was in harmony and happiness.*
> (5/2/19)

Age is a significant factor that influences thought processes in relation to the future. Elsa's lived time focused on the present need of taking care of her husband rather than dwelling too much on the past or spending too much time in the future. Elsa was very grateful for the opportunity to continue her participation in the SGI meetings. Reappraising the priorities in life is essential to personal growth to take action in enhancing the relationship with family as a new perspective on the changes (Lam and Fielding, 2003; Cheng *et al*., 2013, 2016).

Table 11: Fanny's (Participant 6) Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Fanny Age at interview: 57 years Age at diagnosis: 37 years Being: *1. I was very shy and was afraid to talk to people* *2. I used to be very tolerant (13–18 years)* *3. I was very tough (20–37 years)* *4. I was very optimistic (37–57 years)* Being-with-others: *1. I was very fortunate, as all the family members were supportive, including my parents-in-law, my husband, brothers, sisters, and uncle* Being-in-the-world: *1. I was active in SGI*	Theme 1: *I was relatively tired* Theme 2: *The other people* Theme 3: *I was really grateful* Theme 4: *I kept chanting Nam-myoho-renge-kyo*	The Lived Space: *1. I was really grateful* *2. I truly felt the strength of 'Gohonzon'* The Lived Body: *1. I thought it was a defect (loss of breast)* *2. I attached great importance to my body shape* The Lived Time: *1. After the chemotherapy, I experienced challenging times* The Lived Relation: *1. I met other people with grateful hearts*	Fanny was mood-dwelling and grateful to other people for their support of money and time. Her chanting in terms of spatial-dwelling and interpersonal mobility focused on kosen-rufu activities in SGI, and she believed that these activities were a meaning-making and enlightenment process.

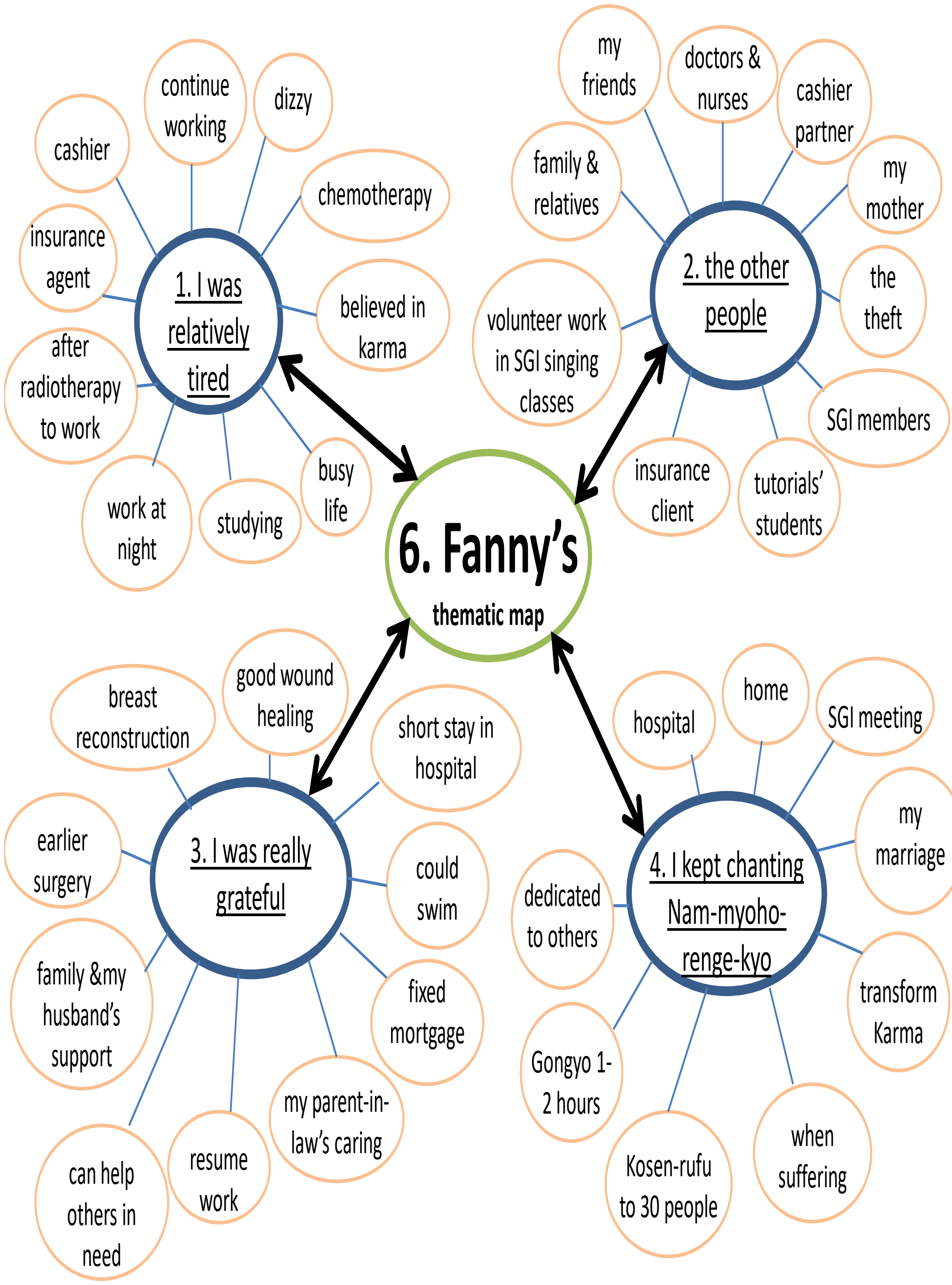


Figure 6: Fanny

5.3.6 Fanny

Fanny was diagnosed with breast cancer, and she underwent a mastectomy and breast reconstruction surgery in 1996. She expressed gratitude that the medical and nursing professionals were able to care for her so effectively.

1. *I was relatively tired*.

Fanny underwent radiotherapy during the day and worked as a cashier at night, which left her feeling physically exhausted.

> *The expense of raising children was great. My husband earned around $10,000 ... I earned $7,000. Our income was not sufficient to pay the mortgage and feed the whole family. I was looking for a way to earn more money ... The household expenses were large. We felt suffocated. We experienced 10 difficult years ... I was very grateful to 'Gohonzon'. I was able to go through this difficulty. Our income could only marginally cover the daily expenses.*
> (6/1/47, 6/1/52, 6/2/78, 6/2/80)

Mitchell (2015) reported that, between 2002 and 2009, there was a significant increase in the literature exploring the feasibility of returning to work after cancer. Being unable to work due to cancer poses a significant financial burden on the individual and their family (Mitchell, 2015). Fanny was the only participant who continued her own business as an insurance agent and a teacher in a tutorial centre. Being so busy day and night, she often became easily dizzy and tired.

2. *The other people*

The support she received from her family was important. Fanny found that financial and social support were the major factors affecting her QOL.

Furthermore, Fanny lived with her parents-in-law. They cared for her children so that she could concentrate on treating her illness, receiving 12 injections and 35 radiotherapy treatments.

> *I realised that I was in need of money during the sickness period. However, money was not as important as family support. The family support was the top priority. Financial support came second ... Everything was not smooth. However, I was able to solve the problem ... My family loved me deeply ... My younger sister was unfortunate and had breast cancer [also] ... I was very fortunate as all the family members were supportive, including my parents-in-law, my husband, brothers and sisters, uncle ... I convinced my family of my religious beliefs at that time.*
> (6/1/49, 6/1/76, 6/2/80, 6/2/19–20)

Her unique experience was that her sister also contracted breast cancer. Fanny convinced all her family members of her Nichiren beliefs and they gave support to each other.

3. *I was really grateful.*

Fanny felt grateful for the coordination of her breast reconstruction surgery. She continually chanted Nam-myoho-renge-kyo for her operation, a concurrent mastectomy and breast reconstruction that was conducted on the Lunar New Year. According to Chinese culture, people seldom have operations during this period. Her spatial- and temporal-dwelling was that her Buddhist beliefs changed her perspectives and brought her peace of mind. As Fanny’s attitudes towards her body shape were positive after breast reconstruction, nobody was particularly aware of her personal issues, despite the fact that her career required socialising with others.

> *At first, I felt uncomfortable psychologically as there would be a defect on my body. Being a female, I attached great importance to body shape. My worry was greatly relieved after I discovered that [a] breast reconstruction operation would be performed to rectify this problem. I felt it was very good that such an operation was available.*
> (6/1/25)

Fanny believed that the operation was psychologically positive for her and it did not impact her later sexual life. Although she mentioned on many occasions that this represented a defect, her husband loved her deeply.

One year after the operation, she said that:

> *It did not affect me that much. There were only a few psychological effects. My husband did not mind. I thought it was a defect. However, it did not affect our sexual life ... In my opinion, it could lead to unhappiness if too much focus is placed on the breasts. I learnt to relax myself. I thought life was more important than mere body shape ... Due to my religious belief, I held different views from others. I adjusted my perception. I thought that health was the most important.*
> (6/1/56, 6/1/58)

After a few years:

> *Regarding the social aspect, I dressed normally. Others did not realise that there was any change to my body shape ... I recommend this operation for those who are younger survivors. There were no negative effects. I could still swim.*
> (6/1/67/15–16, 6/1/60)

After more than 10 years, at the present time:

> *I felt immensely grateful to my family. I had a defect. My husband was not active, but I was tough. He never left me alone, despite my defect and*

> *illness. He loved me deeply. He was caring. He would prepare the evening meal when he returned home early.*
> (6/1/94)

The Chinese do not significantly address sexual life or feminine identity in relation to the loss of a breast (Lam and Fielding, 2003; Cheng *et al*., 2013). Fanny's existential view of being human focused on her lived human relationship with her husband and her engagement with others.

4. *I kept chanting Nam-myoho-renge-kyo.*

Fanny expressed her positive feelings to her team nurse, who was also a member of SGI.

> *I liked to Kosen-rufu in the ward … I told her (nurse) about SGI ... I felt impressed that I had met someone (nurse) who shared the same religious beliefs ... I seemed to have established a close relationship with her. I felt like I was her relative and she took care of me. The feeling was good.*
> (6/1/83, 6/1/85, 6/2/46)

Fanny strongly believed that karma could be transformed. She was active in SGI, interpreting her own view of wellbeing because she possessed the attitude to be able to do something. *Kosen-rufu* means to spread the Lotus Sutra of Nichiren Buddhism. Fanny actualised her life mission of *Kosen-rufu* to convince other people to believe in Nichiren Buddhism. She enjoyed the process of social interaction and engagement with others.

> *The religious beliefs made my mind more peaceful and positive. I thought of 'karma' after I contracted the disease. It was linked to the past ... I prayed to 'Gohonzon'. I worried about the whole process of life. I did not know what to do. I felt puzzled regarding the future. I heard that I would recover after*

> *the first five years ... Other (SGI) members in Tuen Mun also prayed for me ... I established close relationships with other members. I joined activities for a long time. I was really grateful ... I truly felt the strength of 'Gohonzon' ... For the following 20 years, we continued to participate in the activities of SGI to strengthen our confidence.*
> (6/1/87, 6/2/22, 6/2/94, 6/2/16, 6/2/83)

Fanny described how her faith positively influenced her body and mind. She talked about her speedy recovery and rejected the sick role. She accepted her cancer as a form of *karma* and viewed cancer as a sign that she needed to make changes in her life for the future. The positive aspect of spiritual is strongly related to the psychosocial wellbeing of breast cancer patients who viewed such as a meaning-making and enlightenment process (Chan, 2008). Fanny believed that emotions, like joy and anguish, were directly related to health and sickness. The positive aspect of spirituality as enlightenment represents positive correlations with self-esteem, social engagement, and positive social support (Chan, 2008). The more one adopts the survivor identity, the less concerned one is about the perceptions of others (Deimling *et al*., 2007). Creating meaning out of the experience, therefore, is an important cognitive reframing process for women with breast cancer, many of whom are looking for a personally meaningful goal and who maintain hope that a cure might be possible in their survivorship (Ching *et al*., 2012). In Fanny's case, the activities of her Buddhist organisation ensured that she remained socially active, for which she was abundantly happy.

Table 12: Gloria’s (Participant 7) Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Gloria Age at interview: 69 years Age at diagnosis: 32 years Being: *1. I was confident that the Buddhist teachings would definitely enable me to change the fate.* *2. I was still energetic every day* Being-with-others: *1. I always thought ways that I could be better and help others so that others would feel grateful towards me* Being-in-the-world: *1. I could do more Kosen-rufu on a geographical level*	Theme 1: *I suffered excessively* Theme 2: *I would try my best to think of others* Theme 3: *I was busy* Theme 4: *I thought of my mission*	The Lived Space: *1. The cadre in my team gave me encouragement and support* The Lived Body: *1. I was quite thin; I weighed only 70 pounds* The Lived Time: *1. I suffered excessively at that time (due to radiotherapy).* *2. I had high spirits throughout the period (due to chanting).* *3. I felt that the time passed very swiftly (due to SGI activities).* d) The Lived Relation *I would try my utmost to think of others.* *I hoped that others would achieve the highest level of Buddhism.*	Gloria's identity and embodiment were filled with the ‘yes, I can’ spirit because she was a district women’s leader in SGI. Her existential identity was in the Bodhisattva of the Earth and her temporal mobility was focused on the future orientation, which would spread the Lotus Sutra. She seemed to be a living embodiment of vitality.

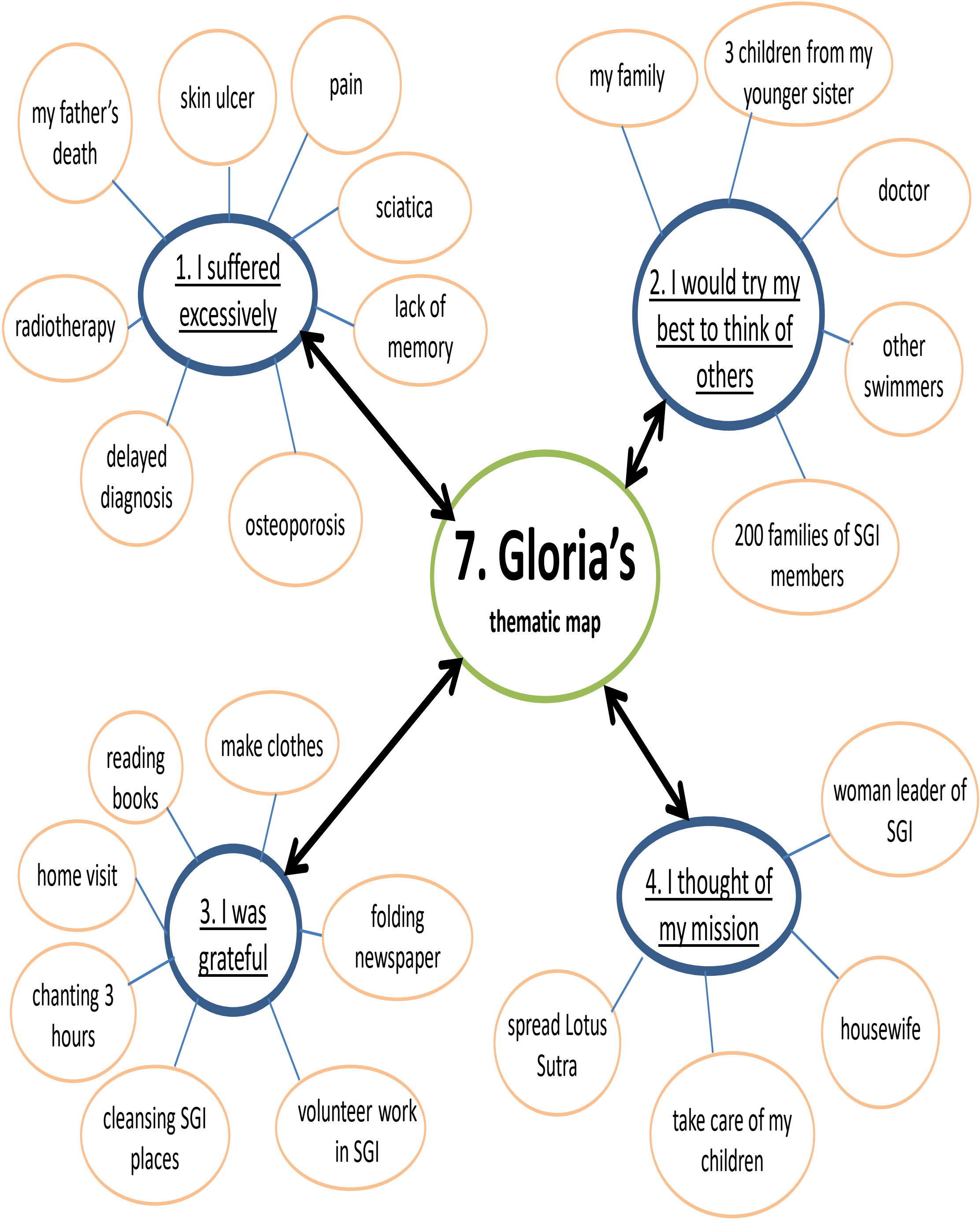


Figure 7: Gloria

5.3.7 Gloria

Gloria was 69 years old at the time of being interviewed. She had developed breast cancer in 1980. She was married and had a son.

1. *I suffered excessively.*

Gloria felt her pain originated from ulcerations throughout her body, which was a side effect of radiotherapy.

> *My greatest stress came from the lack of financial resources … The skin across my whole body was irritated by ulcerations after the radiotherapy was performed ... I had a hard time. Due to the irritation caused by the pus, I felt pain and itchy ... I suffered excessively at that time.*
> (7/1/13)

Her financial difficulties were resolved when the Social Welfare Department assisted with her payment for the radiotherapy. Although she did not undergo breast reconstruction, she went regularly swimming.

> *As I lost a breast on one side, I looked improper when I wore swimming suits ... There was lack of artificial supplements [available] at that time. I made use of cotton to create breast shape. I covered my body with towel once I got out of the pool. No one noticed the difference if I did not talk about it. My body grew better gradually.*
> (7/2/52)

Gloria was extremely tough in confronting the disease. Although Gloria was 32 years old when she was diagnosed with cancer, she felt that the surgery had no adverse effects on her feminine image. Chinese prioritises staying healthy and many women accept the loss of a breast as a chance for survival and to be free of recurrence (Lam and Fielding, 2003; Chan, 2008). Western studies provide inconsistent findings with regard to women with breast cancer, sometimes reporting negative moods and effects because of sexual difficulties and altered levels of intimacy in relationships (Sadler-Gerhardt *et al*., 2010).

> *I did not think of the consequences of losing one breast. I only focused on the plan ahead of me. I thought of some tasks that I had to accomplish in the future. I had never thought about this aspect in the past, or even now. Although I heard of others who had reconstruction of their breasts, I did not have such concerns, and this sentiment remains today. In fact, I was quite thin. I weighed only 70 pounds. However, I was able to overcome these significant challenges. I was still energetic every day.*
> (7/1/42, 7/2/8)

Gloria had a sense of being thin and of becoming energetic. Although her lived body was not satisfactory, her mind was continually focusing on the future to the extent that her willpower was strong and she retained a sense of hope. There were no regrets about her choices, either in the past, present, or future. She believed that her 30 years of survivorship had been granted by 'Gohonzon' and that these years had passed by swiftly.

2. *I would try my best to think of others.*

Gloria and all of her family believed in Nichiren Buddhism. Her husband and son recited the Lotus Sutra and chanted together. Both her husband and son used the embedded role of religion to support each other.

> *To my mind, no matter how much suffering I experienced, I still bore the responsibility of taking care of others.*
> (7/1/20)

> *I recited 'Nam-myoho-renge-kyo'. As all of my family members had the same belief, my husband chanted for me every day ... My son kept chanting intensely for me, as I suffered a lot ... He chanted for me and I felt*

> *more comfortable ... In fact, I was pleased with this. I was pleased with my religion. As soon as I joined any SGI activities, I felt very happy and the annoyances disappeared naturally ... I confronted my problems, I learnt how to solve and overcome.*
> (7/1/26, 7/1/29, 7/1/15–19, 7/1/72)

Gloria's religious beliefs generated a positive way of thinking. Because she was a housewife, her lived space was in her home. She accepted the current situation, and hoped to help others. Gloria’s younger sister was burnt to death in an accident and she was therefore forced to care for her sister’s three children in addition to her own. This life mission enhanced her motivation to cure her illness so that she could continue to care for the four children. Her faith and the SGI members encouraged and supported her during this most difficult time. Participation in the SGI activities made her more comfortable in this respect.

3. *I was busy.*

Gloria described how her faith during her cancer experiences enabled a specific form of connection with others.

> *As a leader of the Women’s Division, I had to take care of around 200 families. I prayed that I would live without problems every day and everyone in the organisation would be able to take care of their own families ... I was becoming more energetic.* (7/2/13)

Gloria was not scared and felt sufficiently confident and resilient enough to fight the cancer. She was engaged with fulfilling her role of mother, while simultaneously performing household chores for her children, such as buying food, cooking meals, and washing clothes. Additionally, Gloria was extremely busy, owing to her role as a female leader in SGI and, therefore, regarded herself as being free of sickness. Gloria showed appreciation for her life and family and found pride in her role as a female leader as well as in her caring relationships with other SGI members' families.

4. *I thought of my mission.*

She expressed no regrets regarding the choices she had made during her lifetime in the past as well as in the present, nor in how they impacted her future.

> *I was granted an additional 30-year life span due to the power of 'Gohonzon'.*
> (7/1/48)

Gloria described her existential identity as the Bodhisattva of the Earth, so that she would spread Nichiren Buddhism (*Kosen-rufu*) in relation to a sense of altruism and duty to provide support to others.

> *The greatest hope was that I could do more Kosen-rufu on a geographical level and there were more talented persons ... It was because SGI held monthly meetings to pray for world peace. The reason I joined was to pray for peace and prosperity around the world. I trusted that we had to work on the basis of family.*
> (7/1/94, 7/2/42)

Her introspection upon personal growth primarily focused on the contemplation of a future in which she would care for others. She continued to learn; help others; and participate in SGI activities such as volunteer work. This included sweeping and cleaning, preparing and folding newspapers and magazines issued by SGI, and making clothes for actors performing in SGI ceremonies.

Table 13: Helen’s (Participant 8) Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Helen Age at interview: 41 years Age at diagnosis: 38 years Being: *1. I felt less inferior* *2. I felt more positive and comfortable* Being-with-others: *1. All the family members, relatives, friends, doctors and nurses were very kind to me* Being-in-the-world: *1. I intended to raise four children* *2. I wanted to help others, i.e., [other] breast cancer patients* *3. I thought that the impossible could turn to possible.*	Theme 1: *I intended to raise four children* Theme 2: *I regularly attended various seminars* Theme 3: *That was a good arrangement of ‘Gohonzon’* Theme 4: *I had many supportive and caring people around me*	The Lived Space: *1. The happiest experience was the support of my family* The Lived Body: *1. My body was fragile after I was discharged from hospital* The Lived Time: *1. I spent more time chanting when I was ill* *2. I also spent more time chanting with others* The Lived Relation: *1. There was a sharing group among the patients that gave encouragement and support to each other*	Helen's identity and embodiment rested on how to be a good mother. Her family represented her spatial and temporal mobility. Although Helen was aware of her bad temper in educating her children, she could control her emotions after chanting.

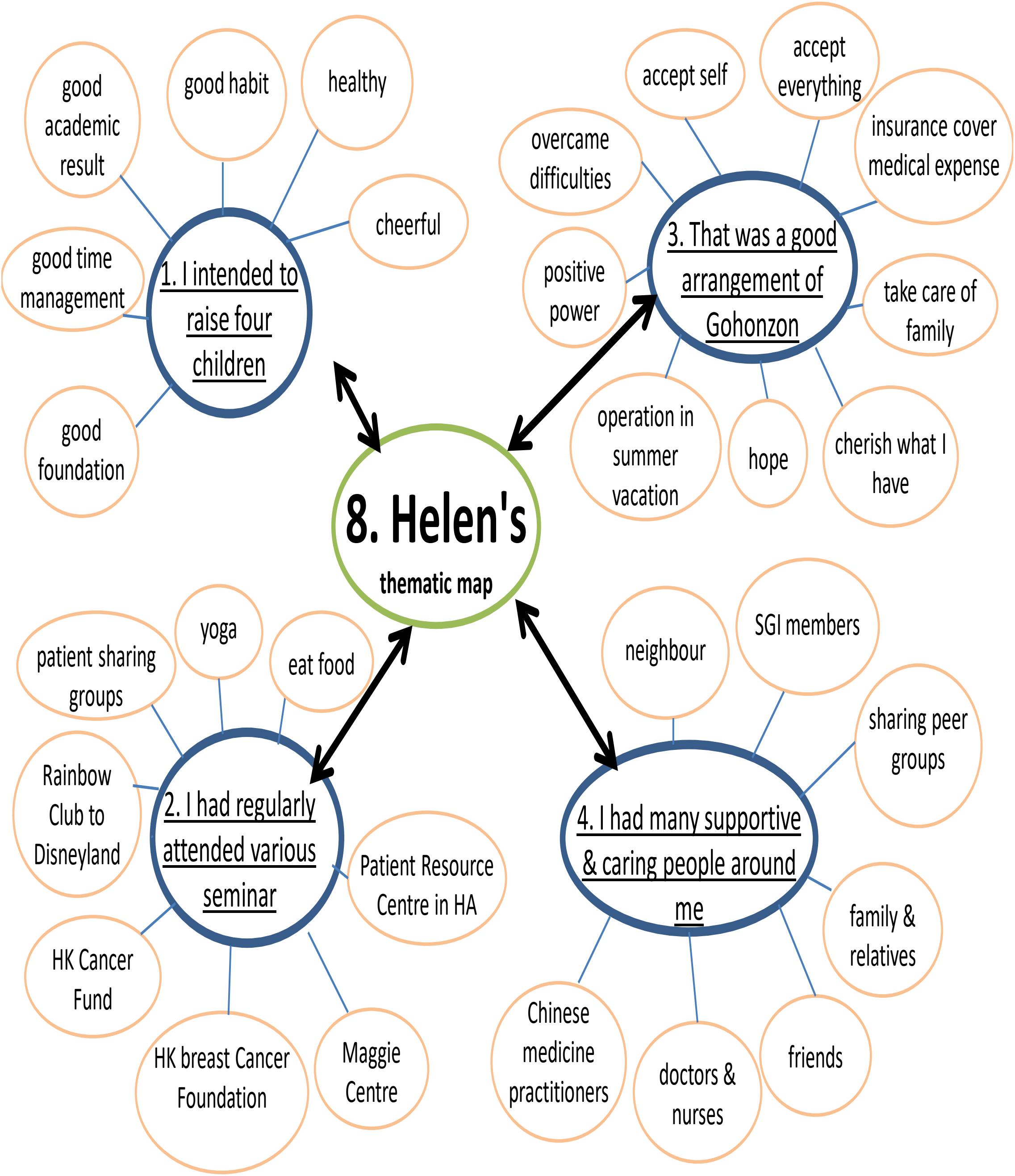


Figure 8: Helen

5.3.8 Helen

Helen, at 41 years old, was the youngest participant with four children. She discovered a lump in her right breast following a self-examination performed in 2012. She underwent a mastectomy and breast reconstruction at Pok Oi Hospital and continued chemotherapy and radiotherapy at Tuen Mun Hospital.

1. *I intended to raise four children*.

Her intention was to raise her children herself.

> *I felt I was inferior since I was small. I lacked confidence. Chanting daimoku enhanced my confidence. If I encountered something that I was not able to handle, I would accept my failure to do it. I prayed and hoped and I continued to put in great effort and proceed every day. There was a hope that I could achieve the target in the future … I intended to bring up four children. I hoped that they placed trust in 'Gohonzon' and were able to overcome the obstacles. Their lives were moving forward. They could grow up happily.*
> (8/2/4, 8/2/6)

Helen thought that she was not as capable as others. However, as she chanted, she did her best. From her point of view, she tried to focuse on how to be a good mother rather than on her suffering. For example, when she taught her children, she was bad-tempered and scolded them when they were not well-behaved. Nevertheless, after chanting, she could control her emotions and grasped a better way to teach her children.

2. *I regularly attended various seminars.*

Helen reported attending various seminars on a regular basis to alleviate her anxiety.

> *I was quite worried … I was worried how long I could survive … A class (HKBCF) with sharing sessions was ... very beneficial, [in] that the other cancer patients shared their experiences… I joined some activities, such as yoga. There were games for children. There were outings too. We went to Disneyland free of charge. It was really good … It catered for the needs of children.*
> (8/1/33, 116, 118)

Helen was the only interviewee to participate in all cancer-supporting organisations, including the Hong Kong Breast Cancer Foundation, Patient Resource Centre, the Maggie Cancer Caring Centre, and the Hong Kong Cancer Fund. Helen and her children also enjoyed the activities of the Rainbow Club.

3. *That was a good arrangement of 'Gohonzon'.*

During this period, the stress principally arose from financial and emotional sources.

> *The greatest difficulty was … financial. Occasionally, I had emotional ups and downs. I usually chanted to pray for a good arrangement when I encountered difficulty ... My insurance agent followed up on my case and claimed the medical fee subsidies on my behalf ... This was due to the good arrangement of 'Gohonzon'.*
> (8/1/74, 90, 96)

Helen thought that her breast reconstruction surgery and chanting were helpful.

> *It strengthened the feminine image to a certain extent. I felt less inferior. Women are generally concerned about the loss of their breasts. I did not have any particular feeling. I reminded myself to perform regular exercises, reinforcing my religious beliefs through chanting and reading books. I*

> *assumed a more positive approach. I spent more time chanting with others ... He (her husband) asked me not to undergo this surgery (breast reconstruction), as he was worried that I would suffer more pain ... He thought that life was more crucial … He accepted the change in my external appearance … At the beginning, I felt tense … I felt much better at present. It was very useful that I reminded myself to stretch my body every day. I felt more positive and comfortable, no matter the physical and psychological aspects.*
>
> (8/1/13, 19, 23, 27)

Helen requested to undergo breast reconstruction to reduce her sense of inferiority. Helen's husband was more concerned about her pain. Helen said that she was psychologically well-prepared because she spent 30 minutes chanting every morning and night. She frequently reported that it was the positive arrangement of '*Gohonzon*' in her being-in-the-worlds.

4. *I had many supportive and caring people around me.*

Helen was very grateful to have many supportive and caring people to help her, including the health care professionals and SGI members.

> *The nurses answered our inquiries as to what to eat or avoid eating, and what precautions should be taken … The mother of another SGI member (Mrs. Lau) had a similar experience. She shared with me that chanting was incredibly useful ... The family members were supportive …They gave mutual encouragement and support to each other.*
>
> (8/1/36, 46, 60, 8, 8/2/129)

According to Helen, she engaged positively in being-with-others and she enjoyed sharing experiences in a peer group. Her family members were supportive, encouraging her chanting to initiate hope and commitment. Such painful and unfortunate events could be described as poison or karmic retribution. The power of *Gohonzon* could certainly convert karma in the manner of ‘changing from poison to medicine’, which would transform a negative situation into something positive.

Table 14: Iris' (Participant 9) themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Iris Age at interview: 66 years Age at diagnosis: 49 years Being: *I was a Buddhist, an introvert and a conservative person* Being-with-others: *I went to worship Guan Yin with others* Being-in-the-world: *I always do some work at Buddhist temple and served others*	Theme 1: *The suffering was more serious than words can explain* Theme 2: *I relied on my religious beliefs* Theme 3: *I only cared about my family* Theme 4: *I tried to do something to help others*	The Lived Space: *I joined the religious assembly* The Lived Body: *1. I was somewhat upset at losing the breast* *2. I simply followed my fate* The Lived Time: *1. This was the way in which we struggled through the hard times* The Lived Relation: *1. I visited the Buddhist temple to give contributions* *2. I contributed to the society*	Iris' mood and body suffered during the cancer journey. Her spatial- and temporal-dwelling possessed a strong will to live to care for her family. After she chanted to Guan Yin Bodhisattva, who she worshipped, feeling grateful that she was still alive. She could explore new horizons in her life in volunteer work, and this contributed to her sense of existential well-being.

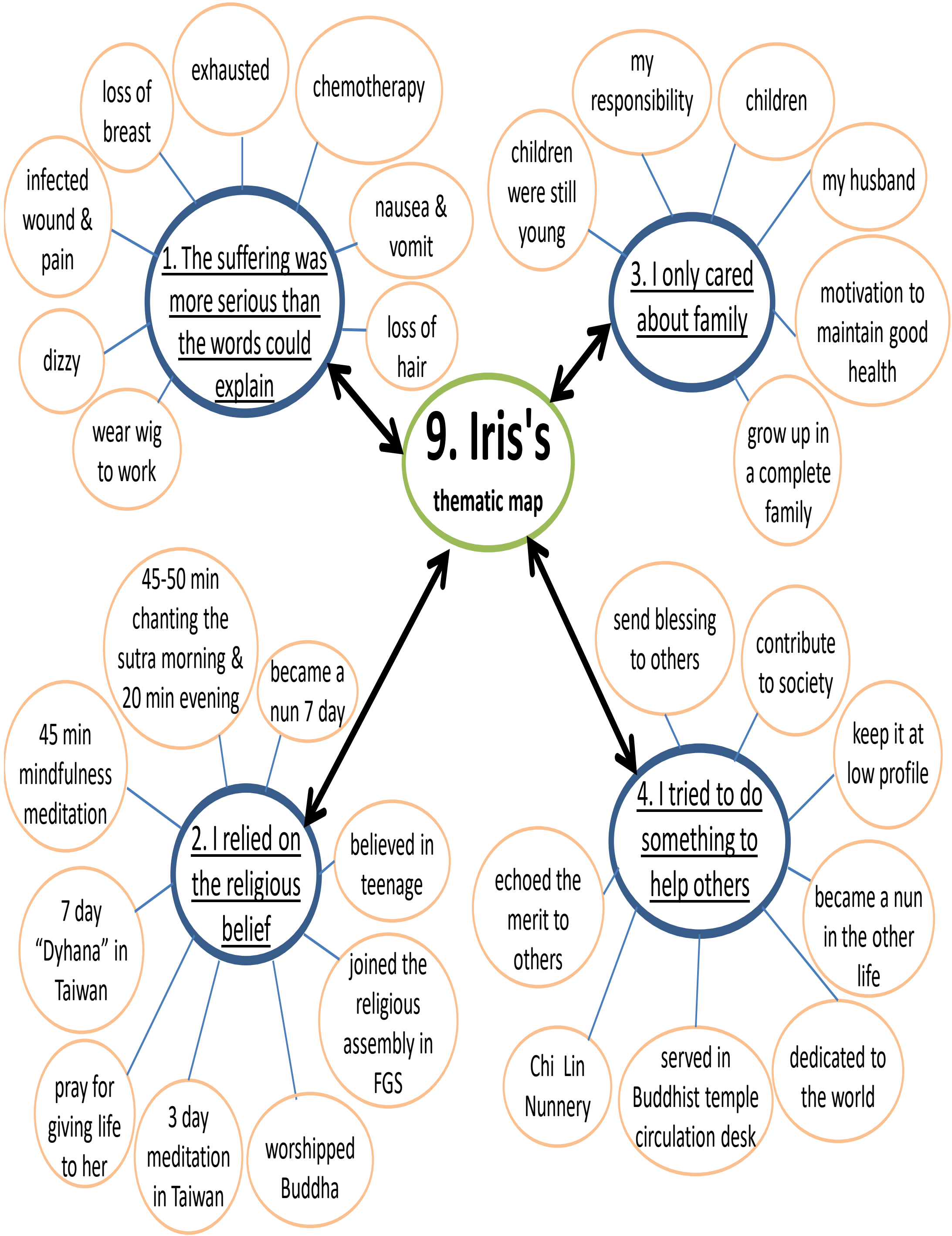


Figure 9: Iris

5.3.9 Iris

Iris discovered that she had cancer in her left breast in 1998. She underwent surgery at the private Precious Blood Hospital. Iris suffered excessively during the chemotherapy treatment, which made her fatigued.

1. *The suffering was more serious than words could explain.*

Iris reported that the suffering was incessant because of the continuous cycles of treatment.

> *The suffering was more serious than words can explain. You could only understand the suffering if you actually had the experience. Then, it came to the second treatment of chemotherapy ... I suffered more seriously than before the treatment. I felt exhausted. I tended to vomit. I was unable to eat. I lost hair and had to put a wig on before going to work.*
> (9/1/21, 9/1/23)

2. *I relied on my religious beliefs.*

Iris thought that her religious belief in the Buddha's teachings would be beneficial for her during this difficult time.

> *I kept chanting until I reached a state of calm. I practised 'Dhyana' or 'deep mediation' as well ... As I became ill, I prayed to Guan Yin Bodhisattva that I could fulfil my obligations. I asked her to give me life. As the children had grown up, I felt relieved. I had no regrets as long as I did not have pain.*
> (9/1/79)

She practiced *Dhyana*, which means deep mediation. She chanted *Namo Guan Yin Bodhisattva* to grant her life. During her period of illness, she did not have knowledge about *Dhyana.* It was only several years after recovery that she joined the Amitabha Buddha Recitation Session at FGS. Every year, she participated in a seven-day *Dhyana* in Taiwan. Upon her return to Hong Kong, she would routinely sit and recite the sutra every morning and night. Iris had practised mindfulness meditation to the extent that she could sit in a peaceful state for 45 minutes at a time in her home setting. Iris' chanting practice led to a meditative state which contributed to her feelings of being calm. There is evidence that meditation reduces physiological arousal, synchronises brain waves, and heightens immune responses (Benson, 1995; Tyson and Pongruengphant, 2007; Fjorback *et al.*, 2011). Iris reported that, after meditation, she gained greater peace of mind, reduced her stress, and achieved better relationships with others.

3. *I only cared about my family.*

Iris' principal difficulties were related to concerns about her children.

> *As my husband had to go to work, no one was available to take care of the family and the children.*
> (9/1/12)

Iris was not inclined to socialise with others. She said that she was an introvert and a conservative person.

> *The motivation came from the family. I love my children deeply. The motivation originated from my responsibilities to take care of my children.*
> (9/1/90)

Her motivation for survival and life meaning was inspired by her family. She believed that no one could replace her role as a mother in caring for her children until they transitioned into adulthood.

> *I took three pills, three times a day. I had taken yunzhi for two to three years... I found that with that (yunzhi), I could maintain good spirits... As my body was weak, I learnt qigong.*
> (9/1/27, 9/1/30)

Iris possessed a strong will to live so that she could continue her responsibilities towards her family. Iris was the only participant who took complementary alternative medicines (yunzhi) and practised qigong (p. xxi) to maintain good spirits.

4. *I tried to do something to help others*.
Iris served at the Chi Lin Nunnery as a circulation desk volunteer.

> *Although I was not infinitely merciful and compassionate, I tried to do something to help others. I had quit my job in 2008 ... Until now, I have been working at a Buddhist temple serving others. I also went to the Chi Lin Nunnery and served at the 'circulation desk'.*
> (9/1/90, 9/1/74)

Iris found that exploring new horizons in her life contributed to her sense of wellbeing. Iris recovered in 2008 and her children have now flourished. Iris perceived herself to have successfully completed her maternal responsibilities, meaning that she could now contribute more to the society with her faith in gratefulness to Buddha. Iris performs voluntary work at both FGS and the Chi Lin Nunnery in order to contribute to the development of Buddhism.

Table 15: Jane’s (Participant 10) Themes

Pseudonym of Participant	Individual Themes	Themes of Lived Experiences	To Clarify the Meaning of Statements
Jane Age at interview: 46 years Age at diagnosis: 36 years Being: *1. I was full of joy* Being-with-others: *1. I felt very peaceful and glad* Being-in-the-world: *1. I was still learning* *2. I did voluntary work*	Theme 1: *The suffering caused by the treatment* Theme 2: *I did not want to ruin the reputation of my father* Theme 3: *My stress came from my husband’s heavy debt* Theme 4: *I became a Buddhist* Theme 5: *The other people*	The Lived Space: *1. I simply thought that coming to this Buddha hall gave me happiness* *2. I was full of spirits here* The Lived Body: *1. My hands became swollen* *2. I could not raise my arms* *3. The doctors stitched the wound with a special method so that no scars remained* The Lived Time: *1. I cried and had tears and laughed at the same time* *2. I felt that the time passed very quickly* The Lived Relation: *1. I intended to help others* *2. I performed voluntary work (in FGS Buddha Hall)* 3. *I was always full of strength*	Jane's spatial and temporal suffering were related to her husband's massive debt and his suicide attempt before her diagnosis of breast cancer. After she became a Buddhist, she believes that she needs to deliver joy and help to others. Her identity and intersubjective-dwelling were focused not only on being a cancer survivor but also as a volunteer in FGS Hall, which gave her peace and a sense of ‘feeling at home’.

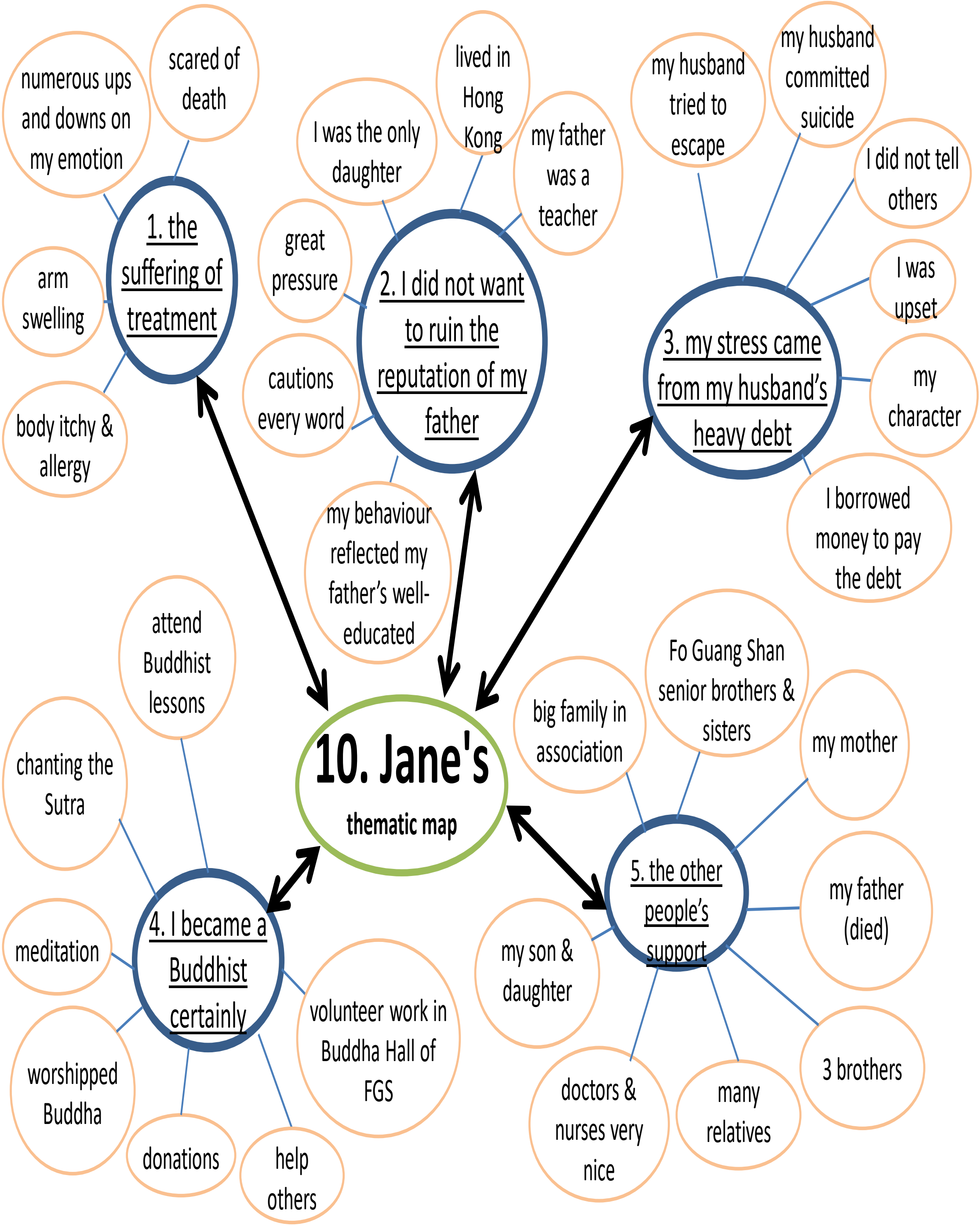


Figure 10: Jane

5.3.10 Jane

Jane was diagnosed with breast cancer in 2006. She underwent a left lumpectomy, chemotherapy, and radiotherapy and suffered immensely during chemotherapy, experiencing dizziness, weakness, hair loss, and emotional distress.

1. *The suffering of treatment.*

Suicidal thoughts invaded her thoughts during the chemotherapy.

> *The thought of suicide came to my mind when I underwent chemotherapy. Fortunately, when I thought of suicide, my classmate called me [to] chat with me … When I underwent chemotherapy, I suffered hard. I was unable to eat. I vomited no matter what I ate. I was unable to sit straight. I suffered a lot. I suffered hard no matter [whether] I sat or slept. I was unable to walk too.*
> (10/1/65, 10/1/72)

2. *I did not want to ruin the reputation of my father*.

Jane migrated to Hong Kong from China in her teenage years, during which time, she was an illegal immigrant.

> *I did not want to ruin the reputation of my father … The pressure was huge. I had to be cautious to ensure that every word I spoke did not ruin my father's reputation.*
> (10/1/41, 10/1/44)

Jane was overwhelmed by the complicated social relationships in her large extended family in Hong Kong. Jane had significant respect for her father because of his great reputation. She paid special attention to the way she expressed herself and her behaviour in her teenage self-identity construct.

3. *My stress came from my husband's heavy debt.*

Jane was released from employment at the hotel where she was employed because Hong Kong was impacted by an economic depression caused by the SARS pandemic in 2003.

> *My sickness was not related to family stress. It was after my marriage. In fact, my sickness came from the problems caused by the relationship with my husband. However, I did not want to tell others, as I did not want to reveal my failure. I was not used to sharing my thoughts in the gatherings. I tried to show my cheerfulness, even though I was upset in my heart. There was a problem with my husband in my family. This caused the sickness. It was related to the stress and my character ... He (my husband) borrowed money from others. Then, he fell into heavy debt .... He tried to escape his responsibilities and attempted to commit suicide. His suicide failed.*
> (10/1/51, 10/1/53)

Her husband's suicide attempt and heavy debt placed a significant strain on her.

> *My husband thought that his responsibility was to earn money. He did not help with the household chores. After that, he actively participated in taking care of the chores. Also, he was not as stubborn as before. He did not insist on imposing his thoughts. He became more sympathetic and supportive towards me … He has also changed. He comes from Chaozhou and is a male chauvinist. However, since I was sick and he encouraged me to come to [the] family hall, we started to share housework together.*
> (10/1/20, 10/2/30)

Her husband changed his attitude and behaviour after her diagnosis of breast cancer. Furthermore, she was grateful for her husband's changes, which enabled him to fulfil his responsibilities of caring for her during her sickness.

4. *I became a Buddhist with certainty.*

Jane was the only participant to have come to the Buddhist faith after having been diagnosed with breast cancer.

> *When I got the disease, I did not believe in Buddhism … I [thereafter] became a Buddhist [and] it certainly helped me. I felt very peaceful and glad. I felt [that] the time passed very quickly. I was full of spirits here ... I was unable to explain the reasons behind my feelings. I was always full of strength ... I intended to help others, which made me happy ... I could offer a donation ... I did voluntary work, which was good for my health … Learning Buddhism also lets me know there is 'karma' and I won't blame anything but [rather] accept. That means, after learning Buddhism, I won't blame this and that, and I learn to accept and face it.*
>
> (10/1/92, 10/1/99, 10/1/120, 10/2/13)

In 2009, she participated in a ceremony in the presence of Master Hsing Yun to proclaim herself a Buddhist. She also enjoyed meditation and singing in the Fo Guang Harmonize choir. Jane felt her intersubjective-dwelling when she volunteered at the Mong Kok FGS Hall on a daily basis. Jane was aware that her Bodhisattva identity and life mission was to serve other people. She also donated money to the educational fund of Fo Guang University, which enabled impoverished children in countries such as the Philippines to receive an education.

5. *The other people's support.*

Her identity as a survivor was influenced by other people. Jane indicated that her interpretation of her cancer identity changed at about five years to 10 years of survivorship. She was reluctant to discuss her disease at the beginning of her survivorship.

> *I have considered myself rehabilitated long time ago. I thought I had recovered after the treatment was completed. I did not think I was a patient as I returned home. I thought I was a patient only when I stayed in hospital … For instance, a few years ago, I went to the Eastern District Hospital to attend a follow-up consultation. As I walked past the chemotherapy treatment room, I was quite upset. However, I would not have the same feeling now. Now, I have faced up to my disease. It was because I was not willing to share it with others in the past. I did not intend to tell others I was sick. I took drugs up to 2013. Now (2016), I am willing to talk about this. For example, I accepted your interview today. In the past, I would have been reluctant to discuss it … I think I am self-worthy. If I am able help, then I will try best to help others. And I will be very happy if I can help others, and other people will be happy as well.*
> (10/1/132, 10/1/137, 10/2/104)

The ability to self-identify as a cancer survivor can change over time; for example, Jane completely accepted her breast cancer after 10 years and became willing to share her experiences in order to provide encouragement to others.

5.4 Section 2: Themes of Shared Experiences

Section 2 provides a synthesis of the findings across all data collected as part of this study, with the aim of identifying shared/similar experiences of women living with breast cancer. These shared experiences bring to light the essences of the phenomena being investigated. Both intention itself (*noesis*: self-awareness) and the intention object (*noema*: breast cancer) appear in the consciousness of an individual's experience. By performing individual thematic analyses of the data, it is possible to tease out the shared experiences of the women involved in this study. These experiences were synthesised into four overarching, interrelated themes of being a breast cancer survivor within the Buddhist faith in Table 16. The themes were categorised using the meanings of the participants' ideas or their own words, as the most representative theme label was selected from one of the participant's individual themes in order to support the definition and contents of that theme.

5.4.0 Example of Synthesis of Shared Experiences

The van Manen steps of Hermeneutic Phenomenology are:

1. Turning to a phenomenon that seriously interests us and commits us to the world

2. Investigating an experience as we live it rather than as we conceptualise it

3. Reflecting on the essential themes that characterise the phenomenon

4. Describing the phenomenon through the art of writing and rewriting

5. Maintaining a strong and orientated pedagogical relation to the phenomenon

6. Balancing the research context by considering both parts and the whole

Step 1: Hermeneutics begets interpretation; my attention was only on the analysis of the participant's thoughts and action(s) that fulfil their Bodhisattva's identity. I wanted to emphasise that interpretation is based on initial intuition and direction; in other words, interpretation is a circle—a beginning is not an end. Step 2: I sought to interpret these themes along with universal themes (I am a Buddhist) and iteratively rewrite in order to shape the focus of the inquiry into what is Buddhist coping. Step 3: The specification of ‘I am a Buddhist’ may be too broad to indicate such a phenomenon. Intuition in the phenomenological sense allows the researcher to imaginatively construct data until a common understanding of the Buddhist coping phenomenon emerges. DeRobertis (1996) gave an example of a chair which generally has four legs. However, can we not imagine a chair with only one thick leg or no legs at all? A bean chair may provide one of the possible answers by showing that legs do not seem to be as essential to the experience of a chair as one may have originally thought. For example, the application of "imaginative free variation" refer to a process of understanding what a particular Buddhist belief and practice is and what such a phenomenon means for the participants. Step 4: I also imagined and described a situation in which their chanting and participation in the meeting of the Buddhist organisation led to a sense of "being and belonging" as Buddhists. What kind of things are most essential to the experience of such a phenomenon? Step 5: I evaluated the participants' Buddhist identities as one of the most important behaviours that expressed their gratitude to the Buddha; they changed their minds and bodies to spread Lotus Sutra as the essence of their behaviours with respect to this phenomenon. In relation to becoming a "Bodhisattvas", the volunteers' behaviours could lead them to transform their negative karma in eternal life. Step 6: Finally, I reviewed some wording that needed to be changed and rewrote the thematic map and tables of shared experiences. Moreover, phenomenological findings are left open-ended because a participant's own perspective may change from time to time, giving new meaning to the different structures of a phenomenon (DeRobertis, 1996). The example of analysing the shared experiences can be seen in the following.

Interpretative Understanding of Shared Experiences: I am a Buddhist

4. I am a Buddhist Theme definitions: Perspectives concerning the impact of Buddhism on the participants' self-identity, self-control, and being-in-the-world.	Amy was dwelling in the present moment to maintain hope because chanting was a sacred experience in a temporary way and provided a sense of peace for her. Betty was in high spirits because she enjoyed the spatial- and temporal-dwelling achieved with chanting that could build a happy relationship with others. Chloe kept on chanting to change her negative karma. Even though she was alone, the meaning of chanting constituted a positive and optimistic space and a time spent at home. Dora had gradually grown into a state of well-being with social support to cope with the sudden death of her husband. During the protective chanting along with the Buddhist monks and nuns, she felt herself being cleansed of negative karma. Elsa experienced a state of well-being in her dwelling in chanting and SGI volunteer work, which gave her a peaceful sense of ‘feeling at home’. Fanny was mood-dwelling and grateful to other people for their support in money and time. Her chanting in terms of spatial-dwelling and interpersonal mobility focused on kosen-rufu activities in SGI, and she believed that these activities were a meaning-making and enlightenment process.

	Gloria's identity and embodiment were filled with the ‘yes, I can’ spirit because she was a district women’s leader in SGI. Her existential identity was in the Bodhisattva of the Earth and her dwelling-mobility was focused on the future orientation, which would spread the Lotus Sutra. She seemed to be a living embodiment of vitality. Helen's identity and embodiment focused on how to be a good mother. Her family represented her spatial and temporal mobility. Helen believed that was a good arrangement of *‘Gohonzon’.* Iris’ mood and body suffered during the cancer journey. Her spatial- and temporal-dwelling possessed a strong will to live to care for her family. After she prayed to Guan Yin Bodhisattva, she could explore new horizons in her life in volunteer work, and this contributed to her sense of well-being. Jane's spatial and temporal suffering was related to her husband's massive debt and his suicide attempt before her diagnosis of breast cancer. After she became a Buddhist, her sense of happiness improved gradually. Her identity and intersubjective dwelling were focused not only on being a cancer survivor but also on being a volunteer in the FGS Hall, which gave her peace and a sense of ‘feeling at home’.

Thematic Table of Shared Experiences: I am a Buddhist

4. I am a Buddhist Theme definitions: Perspectives concerning the impact of Buddhism on the participants' self-identity, self-control, and being-in-the-world.	Amy’s theme 3: I had my religious faith to support me. Betty’s theme 3: I felt peace and comfort after chanting. Chloe’s theme 3: I chanted every time I had trouble. Dora’s theme 4: I am a Buddhist Elsa’s theme 4: I believed in Gohozon. Fanny’s theme 4: I kept chanting Nam-myoho-renge-kyo. Gloria’s theme 4: I thought of my mission. Helen’s theme 3: That was a good arrangement of Gohonzon. Iris’ theme 2: I relied on the religious belief. Jane’s theme 4: I became a Buddhist.

Table 16: Initial Table of Shared Experiences

Shared Experience	Definition of the Theme	Examples of the Participants' Theme
The suffering was more serious than words can explain.	Perspectives on becoming ill and suffering in their survivorship	Amy's theme 1: The chemotherapy side effects were severe Betty's theme 1: The suffering was overwhelming…etc.
I was really grateful.	The participants' feelings or perceptions towards having breast cancer in their grateful hearts and how they showed gratitude to other people	Betty's theme 2: I felt glad and grateful Gloria's theme 3: I was grateful Jane's theme 5: The other people's support...etc.
I would try my best to think of others	How others, including family members, social support, peer groups, and health care professionals, were featured in the participants' experiences of living with breast cancer	Elsa's theme 3: I stressed on family Fanny's theme 2: The other people Helen's theme 1: I intended to raise four children…etc.
I am a Buddhist	Perspectives concerning the impact of Buddhism on the participants' self-identity, self-control, and 'being-in-the-world'	Amy's theme 3: I had my religious faith to support me Helen's theme 3: That was a good arrangement of Gohonzon Gloria's theme 4: I thought of my mission…etc.

Table 17: Modified Table of Shared Experiences

Participant Pseudonym	Shared Experience	Definition of the Theme
Amy Betty Chloe Dora Elsa Fanny Gloria Helen Iris Jane	*The suffering was more serious than words can explain*	Perspectives on becoming ill and suffering in their survivorship
	I was really grateful	The participants' feelings or perceptions towards having breast cancer in their grateful hearts and how they showed gratitude to other people
	I would try my best to think of others	How others, including family members, the Buddhist organisation's members, social support, patient peer groups, and health care professionals, were featured in the participants' experiences of living with breast cancer
	I am a Buddhist	Perspectives concerning the impact of Buddhism on the participants' self-identity, self-control, and 'being-in-the-world'

5.4.1 Synthesis of Findings

A thematic map presenting the four synthesised themes is shown in Figure 11, linking themes from the individual participants to the shared/similar themes.

Shared theme 1: *The suffering was more serious than words could explain.*

Definition of the theme: Shared perspectives on suffering; factors felt to contribute to this stress; and attempting to comprehend breast cancer trajectories, including the entire journey of being a breast cancer survivor.

Shared theme 2: *I was really grateful.*

Definition of the theme: The feelings or perceptions of the participants related to having breast cancer and how they displayed gratitude to other people.

Shared Theme 3: *I would try my best to think of others*

Definition of the theme: How others, including family members, the members of Buddhist organisations, social support, patient peer groups, and health care professionals, were featured in the participants' experiences of living with breast cancer.

Shared Theme 4: *I am a Buddhist*

Definition of the theme: Perspectives of the impact of Buddhism on the participants' self-identity, self-control, and 'being-in-the-world'. The participants' identities are represented by their physical and mental wellbeing as breast cancer survivors and Buddhists.

Figure 11: Thematic map of shared experiences.

5.4.2 Shared Theme 1: The Suffering was More Serious Than Words Could Explain

Participants' perceptions of the meaning of cancer were important in this study. All 10 of the women shared perspectives on suffering, factors felt to contribute to this stress, and their attempts to make sense of their individual breast cancer trajectories. The participants were shocked and scared when they were informed about their diagnosis. Subsequently, while these women and their families received a lot of information following the diagnosis, they nonetheless struggled to cope with the treatment as it disrupted their daily routines. There were two significant sources of stress for these women: the suffering caused by treatment and the pressure to continue to fulfil their roles adequately as mothers. According to the participants' experiences, cancer was viewed as an impermanent journey for the transition from health to illness, which was marked by uncertainty about the future.

> *Betty (P2): Once I discovered I had the disease, I thought life was 'impermanent'. I was very scared and felt helpless.*
> (2/2/8)

> *Helen (P8): I felt helpless and did not know what to do.*
> (8/2/62)

The Lived Body

The lived body is not solely our physical body in the world, although it encompasses the different feelings that affect our emotions (van Manen, 2014; Heinonen, 2015). The participants' cancer diagnosis impacted their body image. For instance:

> *Fanny: I was much scared when I heard of cancer. I thought of many problems … Only the stitches around the breasts could be removed. There were around 70 more stitches at the incision area. The stitches were tight … The whole process was smooth. I was very grateful. The arrangement of the operation was good.*
> (6/1/25, 6/1/36)

> *Gloria: The skin across my whole body was irritated by ulcerations after the radiotherapy was performed ... I felt intense pain because the skin was irritated by ulceration.*
> (7/1/13, 7/1/62)

Despite the differences in the cancer stages at diagnosis, all participants spoke about the essences of suffering and the impermanence of life.

> *Jane: At that time, I was upset at the beginning... I did not understand why I was the victim... I thought about committing suicide. Suicidal thoughts came to my mind when I underwent chemotherapy.*
> (10/1/65)

> *Betty (P2): I was very scared and felt helpless … I stayed at [the] hospital because I was unable to walk and I also lost my memory. I could not even recognise my husband, children, or anybody else. The side effects of the drug were so serious that it had weakened my body drastically ... It was because the suffering was overwhelming. I suffered from vomiting. I hardly had any strength. I was too fragile to carry anything. It seemed as though I was incapable. I could not help my family. I was in financial difficulty. I did not intend to add a burden to my family. Consequently, I thought of death. The greatest stress came from the loss of sleep. I suffered from insomnia for half a year.*
> (2/1/15, 2/1/64)

Jane and Betty both reported that they had experienced suicidal thoughts because they suffered from the physical side effects of chemotherapy, which included nausea, alopecia, muscle, and joint pain. Dora also had a significant negative psychological impact following her husband’s sudden death, which also led her to have suicidal thoughts. Betty reported that she lacked the ability to self-care because of her sense of hopelessness, which was a product of her physical and psychosocial suffering. These feelings were complicated by fear, anxiety, and the sense of loss associated with considerable emotional distress.

The families of Betty, Dora, Fanny, and Jane were significantly financially burdened by the need to self-finance targeted therapies. They sought help from others, such as relatives, friends, and social security systems. They understood how suffering has the potential to connect human beings through their compassion.

All 10 participants experienced fatigue, a change in activity levels, and some emotional disturbances. Although they reported knowledge deficits regarding their diagnosis and treatment at the beginning, they subsequently became familiar with the chemotherapy day-ward settings and procedures, which enabled them to reduce their stress and anxiety levels.

5.4.3 Shared Theme 2: I Was Really Grateful

The women in this study also described their greater appreciation for life that resulted from their experiences with cancer. Although their altered physical functioning and symptoms were distressing, they changed their activities of daily living with a grateful heart. The living meaning of lived experiences seems to hint at certain deeper meanings through introspective reflection (van Manen, 2017), and some of these meanings are reflected in the present narratives. Survivor identity was related to social support activity and gratitude in their cognitive processing.

> *Fanny: Maybe I had a grateful heart. Therefore, I met other people with grateful hearts. I was grateful to the doctor and the nurse.*
> (6/1/83)

First, they perceived cancer as an opportunity for more positive engagement with peers. Second, the participants had their religious faith as a form of support. From the survivor's eye and mind, they recognised breast cancer as an opportunity to discover their Buddhahood, regardless of whatever difficulties they confronted. The writings of Nichiren Daishonin advocate the idea that we must become the masters of our own minds, rather than letting out minds master us. Six of the SGI participants became determined to follow the teachings of Nichiren in order to maintain hope for solutions to their problems.

> *Amy: Yes, I have to maintain hope. Both my daughter and daughter-in-law took good care of me ... At that moment, I had a grateful mind, as they were not obliged to do this for me. They were willing to contribute. I had the faith that it could be transformed regardless of the severity of the disease.*

> (1/1/148, 1/2/81)

Amy, Betty, Chloe, and Helen returned to the hospital in order to attend sharing sessions. They were grateful for the encouragement they received from the volunteer workers in the hospital, because they had previously been cancer patients themselves.

> *Helen: The happiest experience was the support from the people around me, including my family, relatives, friends, neighbours, and old and new SGI members. The SGI members gave daimoku (Nam-myoho-rene-kyo) to me.* (8/1/182)

> *Dora: I was grateful that I had the disease. I realised that my friends and relatives were truly concerned and supportive of me.* (4/1/124)

Participants gained more confidence by sharing their experiences with other breast cancer patients in the ward or by way of patient support groups. Furthermore, Dora and Jane shared their experiences of their Buddhist organisations with other patients order to encourage those who were experiencing suffering.

> *Chloe: I distracted my mind by chatting with others. This made me [feel] at ease and confident. I wrote down the process so that I could share my experience with other patients regarding how to alleviate their suffering.*
> (3/1/39)

Embracing a survivor identity was related to cherishing the most important factors in their lives. The ability to confront their diagnosis and treatment required bravery and a significant life adjustment in response to the changes they experienced. All of them expressed gratitude to and exhibited considerable appreciation of other people. Because their mastectomies had significant impacts on their lives and female identities, their sense of body image was altered. However, they all possessed a strong will to survive and desired to live longer, regardless of the surgery that was performed, and they were not concerned about having mastectomies or lumpectomies. Understanding the side effects could include things such as hair loss, and they had to accept that the changes to their bodies were normal. These women found personal growth and enhanced family relationships when returning to their ‘normal lives’. Embracing a survivor identity not only encouraged others in similar situations; such also led to active engagement in peer support groups. Later, their incredible journeys attracted them to search for their ultimate goals in life. These findings affirm Boehmke and Dickerson’s (2006) earlier study, which indicated that women with fighting spirit were more accepting of their changing personal roles and identities. Nevertheless, this differed from the results of another study in which 27 Dutch women (49%) adopted an escape–avoidance strategy, while others formed a protective shield that remained active in order for them to avoid thinking about their breast cancer (De Vries *et al*., 2014).

> *Dora: I was also aware that I could not escape from ‘impermanence’ once it appeared, no matter what I did. I confronted it joyfully. I did not question why I was the one with this fate and why I was the one who had cancer. I had never thought about this. I only focused on how to face up to it, how to solve the problem, and [how to] act appropriately.*
> (4/2/12)

Dora described her problem-focused coping strategy (personal identity–dwelling) and focused on the present time (temporal-dwelling). Dora had a sense of ‘I can’. This ‘I can’ spirit can help breast cancer patients to endure through the hard times. All of the women in this study showed an appreciation of their significant others, who helped them to rebuild and reconstruct their new selves with a fighting spirit in their lives.

5.4.4 Shared Theme 3: I Would Try My Best to Think of Others

The Lived Human Relations

Living human relations refers to the relationships established with other people in a shared interpersonal space (van Manen, 2014; Heinonen, 2015). Here, we consider how others, including family members, the members of the Buddhist organisations, social support groups, patients' peer groups, and health care professionals, were featured in the participants' experiences of living with breast cancer. The 10 participants regained hope through the support of their families. They received encouragement from their family members, including their husbands and siblings.

Among the longer-term survivors, having greater social support was associated with happiness. All 10 participants maintained social contact with others, particularly with their family members, rather than retreating into social isolation. They shared their perspectives on being mothers and wives, including the factors that they felt contributed to this, and tried to understand their daily lives as housewives.

> *Elsa: I was not a lazy woman. In addition to taking care of my elderly parents, parents-in-law, and children, I spent time teaching [the] children to draw on Saturdays. I felt proud of myself. It was because it was difficult to squeeze [in] more time. I had to attend meetings and lessons. Life was fruitful and normal ...There was not much spare time for activities and entertainment. I attended meetings, folded newspapers, and attended Guardian Club meetings. This was [what] I enjoyed the most.*
> (5/2/22)

Meaning-making is a key problem-solving cognitive process. All 10 participants fulfilled unique roles in their families that were significant motivational factors in their lives. They confronted cancer as a ‘we’ experience that was not only limited to the individual but also shared with family members. Close and extended family ties were the most significant factors enabling them to endure breast cancer. One such home visit was from Mrs. Lau, a breast cancer survivor, who encouraged Helen to raise her children. Nine participants were full-time housewives. These findings affirm the work of other researchers in the field of psychological adjustment among Chinese women with breast cancer (Lam and Fielding, 2003; Ching *et al.,* 2009, 2012). These prior studies focused on the self-evident identity of being a mother rather than a patient.

> *Helen: I prayed for everyone I met. I hoped I could bring fortune to them … I believed that family was very important. I put effort in to cleaning the house so that the children scarcely had sickness. I tried to buy some nutritious food to keep my kids healthy.*
> (8/2/79, 8/2/197)
>
> *Iris: I was only worried about my children and family.*
> *(9/1/51)*

New knowledge was generated from data, including the participant's lifeworld essences, which reflected suffering that transcended words and gratitude for the support of others. For all of the women in this study, the most important real-life contextual meaning was derived from fulfilling their maternal roles, such as performing household chores, thus illuminating the multilevel influences of their motives to cope with their emotional distress and fears of recurrence. These women refused to place more emphasis on concerns about their body images and sexualities. Rather, they focused on their life’s mission, which was caring for their children.

> *Gloria: [In] my mind, no matter how much suffering I had, I still bore the responsibility of taking care of others.*
> (7/1/20)

Committed action can be portrayed as developing patterns of acceptance and commitment behaviours that are consistent with altruisms (Hayes *et al*., 2006; Fung, 2015). The majority of the participants expressed their desire for other people’s goodness and happiness. The findings here are similar to what women with breast cancer in Taiwan described of their lived experiences of focusing on ‘purposes or meanings worth living for’, such as helping others and being needed (Chiu *et al*., 2000).

5.4.5 Shared Theme 4: I Am a Buddhist

This theme is concerned with the impact of Buddhism on the participants' awareness of their self-identity, as well as their physical and mental wellbeing. The participants' quotes reveal their sense of being, being-with-others, and being-in-the-world as Buddhists.

The Lived Space

Being a Buddhist usually entails belonging to a Buddhist organisation and performing religious practices every day. The Buddhist believes that suffering is a perceived causal relationship between the individual and their collective karma; therefore, they may intend to cope using Buddhist strategies (Xu, 2012). The Buddhist's lived space will actively engage with their affirmed and converted Buddhist organisation. The lived space (spatiality) is in fact a 'felt' space, rather than merely a product of mathematical dimensions of length, height, and depth (van Manen, 2014; Heinonen, 2015). All participants in this study adopted positive cognitive reframing consistent with their Buddhist beliefs. Cancer was perceived to be a result of their past karma, but also as something that could transform their fate. According to their quotes, all participants felt grateful for having become Buddhists. Some participants described Buddhism as having transformed their personality from being introverted to being more optimistic and energetic.

> *Amy: I should be optimistic and positive.*
>
> *Chloe: I was more pleasant.*
>
> *Dora: I was an optimistic person.*
>
> *Fanny: I was very optimistic.*

Jane: I was full of joy.

Thus, being a Buddhist may mean being more optimistic.

The lived space in the Buddhist organisation was assigned special meaning by the participants, as it encouraged them and provided a sacred space. All nine participants described their sense of happiness at participating in Buddhist rituals and activities with their organisation. A social support network can produce positive effects on anxiety and depression in cancer patients. All of the participants were empowered to discuss their daily stresses and troubles in their social support groups so that their suffering, caused by emotional distress, was reduced. All 10 participants enjoyed social interaction with others, as indicated in the following quotes.

Amy: I felt that people around [me] encouraged me.

Betty: I made plenty of good friends [at the] Tai Shan Charitable Association.

Fanny: I was very [fortunate], as [my] family and [the] SGI members were supportive.

Buddhism advocates for unfolding four immeasurable traits: loving-kindness, compassion, sympathetic joy, and equanimity (Xu, 2012). The lived space of the Buddhist organisations cultivated positive emotions to enhance the health and wellbeing of the participants. Mahayana Buddhism advocates the performance of volunteer work as an opportunity to reduce bad karma (Xu, 2012).

Amy: I wanted to bring happiness to others. I pursued ‘Kosen-rufu’ by

> *spreading the Buddha’s teachings to others.*
>
> *Betty: I intended to do voluntary work to help others.*
>
> *Helen: It was my intention to do voluntary work. I wanted to help others, i.e., [other] breast cancer patients.*
>
> *Jane: I intended to help others, which made me happy.*

All 10 participants’ life spaces involved joining the support groups of their Buddhist organisations and participating in volunteer work after their respective recoveries.

The Lived Time

All of the breast cancer patients interviewed expressed gratitude for their faith as a Buddhist. Lived time (i.e., temporality) is our temporal way of being-in-the-world, which is our subjective experience; a one-minute experience can either be happy or spent in suffering. It is not measured by an objective time of 60 seconds (Heidegger, 1962; van Manen, 1990, 2014). All of the participants acquired some coping skills through the use of Buddhist meditation practices. Considering the following quotes, all of the participants felt calmer and peaceful after reading and chanting the sutra, which provided them with comfort.

> *Amy: I chanted once I was free. Despite the difficult moments, I had my religious faith to support me.*
> (1/2/39)
>
> *Dora: As I sat quietly, I became aware of the sensation of the breath as it entered and left the nostrils. This enhanced our concentration. We had plenty of worries and troubles. The meditation made the mind peaceful and calm.*
> (4/2/25)

> *Gloria: Thus, I was confident that the Buddhist teachings would definitely enable me to change fate. Since that time, I have strengthened my practice of reciting scripture. I recited scripture for three hours every day. Due to my frequent practices, my family members (i.e., my husband and son) witnessed my strong will in chanting. This gradually reinforced their confidence. They recited scripture with me. I strengthened my practice by gradually chanting additional daimoku.*
> (7/2/8)

Meditation invokes positive religious coping strategies that are often positively related to outcomes like poststress-related growth and increased life satisfaction (Falb and Pargament, 2013). The findings of the current study were similar to those of Falb and Pargament (2013), who showed that positive Buddhist coping strategies might serve as a protective factor and lower levels of depression. This is congruent with the mindfulness meditation literature, which suggests that participants become calmer, at peace, and more confident (Hoffman *et al*., 2012).

> *Helen: I thought it (chanting) helped me a lot. It was because it enabled me to enhance my positive strength to overcome every difficulty. I was less pained. I accepted myself, no matter if it was good or not. I accepted whatever happened to me.*
> (8/2/8)

> *Jane: I also [practiced] meditation. Later, my health [became] better and [made] me more firmly believe in Buddhism, and my health [subsequently] become better and better.*
> (10/2/6)

These findings echo those of the mindfulness literature, suggesting that participants have a high sense of regard for the value of mindfulness practice, which was responsible for them becoming less judgemental of themselves and others and for improving their communication and interpersonal relationships (Kabat-Zinn, 1990; Edenfield and Saeed, 2012; Hoffman *et al*., 2012, Bear, 2014).

5.5 Chanting and Spiritual Well-being

In considering the whole healing journey, Chopra and Kamal (2012) reported that breast cancer survivors tended to emphasise the interplay between physical, psychological, social, and spiritual wellbeing and quality of life. Spiritual wellbeing is concerned with the meaning of illness, religiosity, transcendence, hope, and inner strength. Cancer was perceived by participants as an entrance door through which they discovered their Buddhahood, no matter what difficulties they confronted. All of the women voiced two objectives in life: ‘to actualise their essence of life’ and ‘to study and practice their Buddhist faith’. Their true essence of life changed from passively ‘being helped by others’ to actively ‘helping other people’. Empathy is an intentional process of interpretation that we experience in the world by including our own existence along with others; the other’s existence is present in intentional communion (Moustakas, 1994). All six SGI participants chanted the Lotus Sutra. Prayer in Nichiren Daishonin’s Buddhism is profoundly different from prayer in other Buddhist organisations. These women found their inner strength, hope, and life’s mission of promulgating their Buddhist faith to the world.

The Buddhist nature draws upon people’s inner resources of courage, wisdom, and compassion to resolve the four sufferings: birth, aging, sickness and death

(Ikeda, 2003). Buddhists believe that chanting contributes to the limitless positive potential (Ikeda, 2003). Chanting is perceived as an action taken to improve and restore health and well-being. Khalsa *et al*. (2009) observed that the chanting meditation state increased the cerebral blood flow in the right temporal lobe and the posterior cingulate gyrus. Gao *et al*. (2017) explored the effects of repetitive silent chanting of the name of the Amitabha Buddha and analysed electroencephalography data from 21 Buddhists regarding the brain's response to viewing negative pictures. Results showed that chanting modulates the early fight-or-flight responses to negative stimuli but also affects the late-stage emotional/cognitive neural processing as compared to the no chanting condition (Gao *et al*., 2017). Chanting influences our brain to promote stress and coping responses including in our daily actions and interactions. Buddhist practices can constitute a kind of peace for women and are linked to their sense of existential well-being, no matter what the outcome. Their determination was actively applied to Kosen-rufu, which implies a significant desire for the widespread propagation of Nichiren Buddhism. The participants were not praying to an external entity (e.g., deity) to bestow something upon them. Instead, their prayer in this context was an affirmation, their determination to solve their own problems.

5.6 Chanting and Existential Well-being

Existential well-being refers to one's sense of meaning in life. Cancer patients are especially prone to existential distress and, in the short term, existential interventions can improve their quality of life, a finding which is in line with the meta-analysis by Bauerei et al. (2018).

Each participant’s narrative discussing their existential well-being is as follows:

Chanting, Amy believed, would eliminate her suffering – that it is a natural solution for her problem. Chanting, she explained, would increase her good fortune, and its logic was similar to saving money. Confidence was the key to success. When people caught diseases, it shook their confidence. All we know, she believed, is that the law of cause and effect is at work, and whatever challenges we are facing, they are a direct result of the karmic cause we made in the past. She believed that some people only kept grumbling but forgot about chanting so that they failed to have any Buddhist merits and virtues. Suffering could be transformed through chanting. Transformation means to have changed our karma. Amy felt that she was in a position to explain how to confront the disease without fear and believed herself to be a good role model in the SGI community.

Betty was severely suffering after the side effects of her chemotherapy. She felt helpless and thought of suicide during difficult times. She also felt anxious and depressed because of her poor financial condition; she was worried about becoming a financial burden to her family. She was scared to think or talk about "death" which was in line with Chinese culture. After chanting to the Guan Yin Bodhisattva, she felt that her life was granted by the Bodhisattva and became grateful to have a new life. She placed less emphasis on death, on how long she could survive and became optimistic.

Chloe became an SGI member ten years ago, and she was grateful because one of the members accompanied her to follow up consultation during her cancer journey. This member acted as a "Bodhisattva of the Earth" and shared her feeling that she was helpless. Chloe prayed to "Gohonzon" for her fate of sickness be changed to mission. Her existential mission, she believed, was to convince others to change the fate of sickness through chanting. She also assisted others in learning the teachings of Nichiren Buddhism. She felt happy when others got rid of their pain and suffering – happiness that was different from the happiness originated from material things.

Dora had believed in Buddhism for 15 years. Even though she was diagnosed with breast cancer five years ago, she was not scared. As taught by the Hsing Yun master, she practiced meditation every day and constantly attended her Buddhist class. She did extensive volunteer work in the dharma assembly at the Mong Kok Fo Guang Shan Hall. She prayed for the good fortune and happiness not only for herself but for all living beings. She chanted "Namo Amitabha" and also did some chanting services for those who were dying in the hospital.

Elsa focused on her role as a caring mother in her family and seldom had leisure time. She was proud of herself because even though she was eighty years old, she could manage her family and her husband, who had dementia, well. Every day was earned, and she was happy because it meant victory and an opportunity to learn her most valued life lessons. She continued to chant, hoping for world peace and harmony. To those struck by unfortunate fate, she offered the merits of chanting. She prayed for the prevention of disasters and earthquakes, and she prayed for everyone to have a stable home.

Fanny discovered that she was carrying out a “human revolution” by joining the activities in SGI for 20 years. Chanting creates a safe space in which illness is not viewed as the end of the world but instead as an opportunity for growth. She shifted her focus to confidence and changed herself. She did not pressurise others; rather, she was concerned for them. Though she held money as important in her younger days, she changed herself and overcame her financial difficulties. As she earned more money, she wanted to help other children in her Tuen Mun community. She has convinced over 20 people to believe in Nichiren Buddhism and join the SGI.

Gloria was both a housewife, taking care of four children, and a SGI women leader. In 1973, her younger sister was burnt to death in a fire, leaving behind three children. Gloria was supported by SGI and encouraged by Buddhist teachings. Her existential role is taking care of her family and the SGI members. When she got sick at the beginning, she could not predict her future. For three hours every day, Gloria chanted that she wanted to continue her life for the sake of her husband and children. This meant that her whole experience was anchored on preparing to care for other people and hoping for the future. She volunteered at SGI and prepared costumes for the Hong Kong Soka Gakkai kindergarten students’ ceremony.

Helen thought that her Buddhist belief enabled her to overcome her breast cancer. In particular, at the beginning stage of her sickness, several SGI members came home to visit her. Reframing the illness is a coping process of existential meaning-making. Helen shifted her focus to her children rather than to her illness. She recalled one SGI woman who had also suffered breast cancer over 20 years ago, who encouraged her how to be a good mother. Helen was bad-tempered and scolded the kids when did not behave well. After she began chanting, she could control her emotions and grasp ways to teach her kids. Despite her husband's objection to her Buddhist faith, she kept on chanting for over two hours every day to gain the confidence to manage her difficulties.

Iris learned about Buddhism for ten years, and she felt that she became more optimistic. Whenever she felt upset, she performed sitting meditation and calmed herself down. She chanted to Guan Yin Bodhisattva, who she worshipped, feeling grateful that she was still alive. Her cancer strengthened her belief in Buddhism, and she kept studying Bodhisattva's teachings. Later, she went to Fo Guang Shan in Taiwan and joined the meditation assembly for seven days, which made her heart more peaceful and made her feel more relaxed and her body stronger. Her religious belief was beneficial in her recovery as she was able to find meaning in life. She spread the merits of chanting scriptures to others, spreading them to bring peace to the world and all lives.

In 2006, Jane received a lumpectomy. She had not joined any Buddhist association before. She was the only participant to come to Buddhism after having been diagnosed with breast cancer. She prayed to Guan Yin Bodhisattva to save her, and she felt that the Buddha and the Bodhisattva would offer her their blessings. Since she became a Buddhist, she joined the Dharma class and has continued till now, practicing meditation and sit-in to be attentive to her breathing. During these years, Jane has enriched her belief in Buddhism. As a disciple of master Hsing Yun, she believes that she needs to deliver joy and help to others. She has continuously taken part in voluntary work, regardless of the Buddhist Chapel or community, to share the joy with others. Being a Buddhist has changed her relationship with her husband and the people around her. She has become less stubborn and more willing to communicate with others.

Existential therapy does not include hope programs, life reviews and dignity therapy; however, sound theoretical assumptions and models for how benefits are interrelated and might be affected by outcomes have not yet been developed. The Buddhist teachings are the most significant sources to help participants construct their existential well-being and, therefore, have the confidence to cope with issues concerning life or death. This can be achieved because they believed that reincarnation and karma could explain their sources of suffering. There are many schools of Buddhist teachings; for example, while the Chinese Mahayana Buddhism may emphasise reincarnation to the Pure Land, the Thai Theravada Buddhism may focus on preserving the Buddha’s doctrine of meditation and monastic discipline, and the Tibetan Mahayana Buddhism may visualize the image of the Buddha (Lee *et al*., 2017). Chanting is the Nichiren Daishonin's Buddhism practice, and it is the ultimate Mystic Law or true essence of life that permeates everything in the universe (Ikeda, 2016)

According to Buddha's teaching (Dharma), life is impermanence. Impermanence expresses the Buddhist notion that all conditioned existence, without exception, is transient, indicating that everything changes (Phillips *et al*., 2012). The Buddha explains that “Consciousness may exist having matter as its means, matter as its object, matter as its support, and seeking delight it may grow, increase and develop, or consciousness may exist having sensation as its means… or perception as its means… or mental formations as its means, mental formations as its object, mental formations as its support, and seeking delight it may grow, increase and develop" (Rahula, 1958, p. 41). Meditation can help individuals cultivate self-compassion and eliminate critical thoughts (Lee *et al*., 2017). However, chanting is different from meditation.

Chanting is an enlightenment process to reflect our innate Buddhahood. The Daishonin teaches us that the power of Gohonzon has no limits and, therefore, we should have the courage to pray with all our hearts for what we truly want (Ikeda, 2003). Chanting "Nam-myoho-renge-kyo” can divert your consciousness; therefore, you will have the wisdom to focus on "they" and not only "you", which will cultivate a sense of compassion. Chanting can alter your karma because loving and kind actions will endorse high levels of greater spiritual well-being. The Buddhist teachings emphasise that everyone should be kind and respect each other. The theoretical assumption of chanting is a gaining of Buddhist merit process. How does chanting constitute a space of dwelling? Dr. Ikeda (1995) explained the Nichiren Daishonin's Buddhism model of "faith, study and practice" in his book the *New Human Revolution*. Chanting is a transformative practice, following the principle that “practice was supported by faith and study”. “Faith” refers to confidence, and it means to believe in the Gohonzon. “Practice” relates taking into action. Practice means to chant “Nam-myoho-renge-kyo” and perform “gongyo” twice daily, and to teach others to do the same. According to the teachings of Nichiren Daishonin, “gongyo” means to recite the Hoben (second) chapter and the Juryo (sixteenth) chapter of the Lotus Sutra and chant “Nam-myoho-renge-kyo” in front of Gohonzon. Gongyo is performed each morning and evening, and it is the most fundamental practice of Nichiren

Daishonin's Buddhism. “Study” implies the study of Buddha’s teaching. It means to read the writings of Nichiren Daishonin and apply them to our daily lives. Among these three, faith is the most fundamental for attaining Buddhahood. Faith gives rise to practice and study; practice and study serve to deepen one's faith. This model of study, faith and practice develops wisdom, compassion and courage. Nichiren Daishonin's promise is that when we chant sincerely, no karma is immutable, and we can challenge and change every situation for the best possible outcome, including our health and well-being. Buddhism is not a miracle cure – it is a reason. We chant to have the wisdom to make the right choices in our life.

5.7 Chapter Summary

In this chapter, the meaning of living with cancer impacted the lifeworld stories of the 10 women explored and the findings are illustrated with thematic tables and maps. Their unique lifeworld stories reflected the individual context and were categorised under the lived space, the lived body, the lived time, and lived human relations. The hermeneutic interpretation strived to acquire multiple interpretations from retrospective descriptions of the women's lived experiences. Examples of 'I am a Buddhist' described how the hermeneutic understanding of shared experiences developed. All of the women embraced Buddhism and performed chanting and meditation, which can serve build up one's spiritual well-being. These women reported that chanting enabled them to be open and to accept all experiences in their way, through having a nonjudgemental attitude, patience, and kindness. The next chapter will discuss the findings further and present recommendations for practice.

Chapter 6: Discussion

6.0 Chapter Overview

This chapter summarises the researcher's understanding of the participants' experiences. Section 1 critically discusses findings in relation to the literature review covered in Chapter 2. Section 2 focuses on the new concept of Buddhist coping. The religious coping experiences of Buddhist practices can add new knowledge to the existing literature. This is significant, given that previously reviewed research has been dominated in Western countries by faith in God. The interpretation of the present findings is therefore unique. It will be presented in in tabular form and discussed in more detail. The participants' subjective sense of 'survival' signifies the meaning of life priorities in Buddhism. The four hermeneutic interpretation patterns included (1) transforming negative karma, (2) opening up one's own Buddhahood, (3) fulfilling the Bodhisattva identity, and (4) hope and future. Within this interpretation of findings, important elements were extracted that related to the women's experiences of living with breast cancer. Section 3 presents a review of the strength and limitations of this study and conclusions regarding the implications and suggestions for the practice of nursing. Finally, it is hoped this study will act as a stepping stone to encourage future research in psychoneuroimmunology regarding the effects of chanting in meditation.

6.1 Quotes from Ikeda: Human Revolution

'Human revolution is the work of transforming our lives at the very core. It involves identifying and challenging those things which inhibit the full expression of our positive potential and humanity. Nichiren Buddhism is based on belief in a pure, positive, and enlightened condition of life, which exists equally within all people. We break through the shackles of our "lesser self," bound by self-concern and the ego, growing in altruism toward a "greater self" capable of caring and taking action for the sake of others—ultimately all humanity'

(Ikeda, 1995)

6.2 Section 1: Shared Experiences in Previous Literature

6.2.1 The Hermeneutic Significance of Understanding Experiences

The art of understanding involves a circular relationship (Gadamer, 1994) in which the participants and the researcher are equal. I acknowledged my personal perspective when outlining the data collection methods. The researcher thus acts as a research instrument in a process that cannot separate their prior lived experiences, with the existing attendant bias and values, from affecting the questions asked in the interview. Moreover, a shared Buddhist faith presents a challenge regarding attempts to distinguish the investigator's and participants' views of the world.

Together, we expressed ourselves in an open-minded, working, and respectful partnership throughout the research process. Everything was interrelated, and experiences can be interpreted as a whole or as parts of the hermeneutic circle (Gadamer, 1994; Halkett *et al.*, 2007). This issue relates to the temporal and spiritual dimensions of Buddhism. It was easy to build trust and rapport, even in the first interviews. Both the researcher and the participants shared the inner and outer fusion of horizons.

6.2.2 The Fusion of Horizons

According to Gadamer, ‘the hermeneutical rule [is] that we must understand the whole in terms of the detail and the detail in terms of the whole’ (Gadamer, 1994, p. 291). The interpreter must locate a situation in terms of their own historical horizon that forms a historical enlightenment between the present and tradition

(Gadamer, 1994; Austgard, 2012). The hermeneutic process has developed to a point at which where the interpreter has captured the coherence of the author’s texts and the text can now express the author’s meaning regarding the case (*die sache*). A fusion of horizons (*horizontverschmelzung*) was made possible through ‘being’ in the Buddhist dialogue and ‘being’ in the Cantonese dialogue. In sharing Nichiren Buddhist beliefs and values, the inner horizons linked to my own sense of historical consciousness and enlightenment. Acknowledging my 16 years of personal experiences in Buddhist practice and my 30 years of experience with clinical prejudgement in nursing contributed to this. For example, we talked of the merits of chanting, Kosen-rufu, and meditation, which were all demonstrated to be horizons of past experiences. The classical meaning of the Buddhist terms envisioned the anticipation and actual understanding of the details and of the whole. When the individual's language was understood properly, it facilitated an understanding of the meaning of the entire dialogue. The Cantonese construed a sentence and we understood each other quickly through our shared mother tongue language. The interpretative process involved listening to the tape repeatedly. I made sense of the data using Cantonese and Chinese. Attached are examples in English of the transcripts and coding of participants’ interviews.

Outer horizons link to Chinese cultural factors such as an understanding of the Chinese medicine referred to in our traditions. Furthermore, I respected the Chinese norms and rituals in our Hong Kong–based social interactions. Chinese rituals encourage people to respect each other and the practice of giving to others is common, such as in the case of offering some fruit to friends as a courtesy during a home visit. I therefore bought some fruit for Amy, Elsa, Gloria, and Helen’s families on my home visits. For example, Helen (P8) introduced her father and mother to me; they were very welcoming. Helen's mother described to me her actual proof of how the experience of chanting had helped her to solve her problem, and stated that she had belonged to SGI for over 30 years, which had imbued her with great confidence. Even though we had a short conversation, we trusted each other because we shared the common goals of Kosen-rufu. Helen also showed me a diary of her experiences fighting breast cancer. Her schedule book recorded her consultation with a Chinese medicine practitioner and the detailed dates and times of the treatment process. Each participant’s experience was thus understood through the hermeneutic circle. The details of each complete text were read and interpreted within broader historical and cultural contexts. Furthermore, in terms of Chinese culture, I felt it might be annoying and would ruin the relationship of trust if I discussed the same topic three or four times with the participants.

6.2.3 Significance of the Themes: Relating the Findings to the Literature Review

In this section, I will discuss the synthesis of the interpretation of findings into three themes, as follows:

Theme 1: Stress and Coping Response

Theme 2: Transition Pattern of Self-Identity

Theme 3: Spiritual Coping

The previous literature review focused on women's discussions of the transition from a patient's identity to a survivor's identity. The findings regarding themes 1 and 2 were supported by my research. Theme 3, however, differed from the religious coping present in Western countries. I thematically interpreted findings into four themes of Buddhist coping. Each of these themes will now be discussed critically and contextualised within the wider literature.

6.2.4 Shared Themes of Breast Cancer Survivors in the Existing Literature

Theme 1: Stress and Coping Response

Coping is defined as the ability to adapt to stressful situations (Rice, 2012). Lazarus and Folkman's (1984) argued by way of their transaction-based theory that coping involves a conceptual effort to redefine the stress; adapt to the situation; and reappraise the perceived threats that could emerge at the three levels of social, psychological, and physiological. The concept of coping also includes the individual differences and characteristics of the personality and the environment (Lazarus & Folkman, 1984). Adaptation occurs subsequent to coping, and includes problem-focused coping and emotion-focused coping (Lazarus & Folkman, 1984; Kvillemo & Branstrom, 2014). Problem-focused coping entails managing or altering the problem within the environment that has caused the distress, while emotion-focused coping involves regulating the emotional response to the problem (Lazarus & Folkman, 1984). If the stressful events are managed effectively, the short-term and long-term adaptational health outcomes can be achieved and the results will be good health, effective social functioning, and positive morale (Lazarus & Folkman, 1984; Lyon, 2012). However, psychosocial stressors can influence various aspects such as tumour growth and metastasis; for example, T-lymphocytes function at a reduced level during stress and are no longer capable of destroying mutant cells before they subsequently multiply and cause damage (Powell *et al.*, 2013; Greenberg, 1993).

All of the participants self-detected their breast cancer by chance, which was similar to the findings of the Hong Kong Breast Cancer Registry (2014), where 88.4% of breast cancers were discovered by patients. Within this research, 4,497 of the cancer patients (37.3%) had experienced living with stress more than 50% of the time (Hong Kong Breast Cancer Registry, 2014). Women with breast cancer, therefore, have a lot of questions about time and care. Uncertainty surrounds making a choice and worrying about having made the wrong decision. Halkett *et al.* (2007) found that patients invoke several decision-making models when receiving cancer treatment including 'paternalistic', 'shared', 'informed', and 'physician as an agent' models. In the current research, all of the participants stated that they were fully informed and felt free to choose between a mastectomy or lumpectomy.

Their main concerns were survival and reducing the risk of recurrence. They accepted the recommendations of the surgeons and oncologists. The most difficult time for them involved suffering from the short-term side effects of chemotherapy including fatigue, nausea and vomiting (emesis), stomatitis, and alopecia (loss of hair). For example, Chloe experienced severe bone pain, myalgias (pain in the muscles), and neuropathy (pain and numbness in the limbs). Long-term side effects often include permanent premature ovarian failure in premenopausal patients and potential cognitive impairment (Zhu *et al.*, 2013). Betty and Chloe, for instance, described the cognitive impairment they experienced in their postchemotherapy treatment journeys. As described in the existing literature, a common phenomenon was experienced in that the women needed to make many decisions and all feared recurrence. Breast cancer involves the disruption of ordinary life roles (Kvillemo and Branstrom, 2014).

Chinese culture places a greater emphasis on family consultation in decision-making than do typical Western cultures (Olsen *et al.*, 2010). Every decision has the potential to significantly change their lives in the long run. The experience of breast cancer survivorship includes anxious thoughts surrounding cancer recurrence, changes in relationships with significant others, and alterations in self-image (Sampoornam, 2015). All participants employed both emotional coping and problem-solving strategies, in line with previous research findings. Chloe in particular selected avoidance as an emotional coping method. All felt grateful to their family for the social support they provided, which helped to ensure the smooth transition of self-identities from patients to survivors. Furthermore, the patients developed acceptance and became committed to their volunteer work in the Buddhist organisation. Interestingly, they largely did not believe in fatalism. All of them talked about their faith in a changing destiny and refused to give up. Their religious and spiritual coping was different from that in Western countries, which will be discussed further in the next section.

Theme 2: A Pattern of Self-Identity Transition

The more adaptation to stress is facilitated, the greater the level of well-being and development of health is (Kvillemo and Branstrom, 2014). McCaughan *et al.* (2012) conducted longitudinal interviews with 38 individuals (24 men and 14 women) on four occasions over an 18-month period following a diagnosis of colorectal cancer. The aim of this research was to explore how gender influences coping. Three themes emerged from the data including 'new normal', living with uncertainty, and support needs (McCaughan *et al.*, 2012). Although men and women often reacted in the same way, many women continued to experience long-term physical side effects, whereas many men indicated they had no problems (McCaughan *et al.*, 2012). The Chinese cancer survivors' experiences were similar, including physical and psychological sequelae, family distress, an increased financial burden, and disruptions to their social functioning and sexual life (Zeng *et al.*, 2011). This may be attributable to prejudices towards their gender identity and stereotyped views of masculinity or femininity. For instance, women have been typically described as more emotional, compassionate, and yielding, whilst men are characterised by strength, self-reliance, and an inability to express their emotions. Most participants reported receiving strong support from their husbands. This finding is similar to the results of previous research, in that the most helpful support comes mainly from the spouse and family and the most harmful effects are caused by mismanaged family issues (Antoni, 2013). For example, unmarried and widowed women have poorer survival rates than do married women; therefore, being married and having a good marital relationship has been one of the main protective factors regarding breast cancer outcomes (Ballantyne, 2004).

Furthermore, higher spousal support is associated with higher levels of psychological adjustment as well as lower levels of depression in breast cancer women (Caple and Schub, 2014). In a 10-year longitudinal study carried out by Ballantyne (2004), married women survived longer than widowed women; marriages involve social participation, which enhances the mental and physical health of breast cancer survivors so that their partner's 'fighting spirit' is nurtured, along with self-expressiveness, which facilitates better adjustment. The engagement with coping thus comes from an acceptance and positive reappraisal response to the self and the current situation or the environment (Kvillemo and Branstrom, 2014). However, women with breast cancer who chose disengagement and avoidance forms of coping suffered from lower well-being and poorer health outcomes (Kvillemo and Branstrom, 2014). Health care professionals should therefore be aware of social stereotypes that might influence the physical and psychological care given to cancer patients. Commonly shared themes amongst breast cancer survivors present in the existing literature are summarised in detail in Box 3.

Furthermore, the breast cancer survivors wished to have a second chance at life. Women were motivated to care for themselves by developing a variety of actions that included a continued search for personal fulfilment and spiritual growth (Lally and Underhill, 2012). They felt grateful because they were still alive and able be a mother to their children, and this mattered more than possessing any material objects, financial rewards, or a successful career. The cancer diagnosis enabled them to reflect and reevaluate their self-identity and what was important in their life. The most important role is that of maintaining normality through the undertaking of familiar routines and the maintenance of mothering practices between the present and after their diagnosis. Fisher and O'Connor (2012) suggested that routine nursing assessment should include an initial acknowledgment of the patient's mother role regarding their children’s concerns and issues, and nurses should provide a proper referral for support for any problems at the very beginning. Furthermore, nurses can help to facilitate patients’ adjustment by increasing their sense of empowerment, enhancing their self-esteem, and providing commendation for coping with adversity in their lives.

Box 3: Shared Themes Amongst Breast Cancer Survivors in the Existing Literature

- Presentation of palpable breast lump and suddenly being diagnosed
- Acceptance of uncertainty as an ongoing process
- Experience of disruptions to the physical, psychosocial, and spiritual aspects of their lives
- Being fully informed of the diagnosis and treatment choices
- Financial difficulties in purchasing target therapy medicine
- Willing to accept the mastectomy or lumpectomy
- Sexuality or femininity is less of an issue in Chinese culture
- The chemotherapy was the most difficult experience
- Thanks for ‘others’ including regarding family, marital, and social support
- Continue long-term follow-up and hormonal therapy
- Motivation came from taking care of children
- Cancer can impact people's values and their relationships with others
- Searching for the meaning of life
- Reorganising life priorities to help others
- More active, problem-solving, and optimistic attitude about the future
- Attempting to live for their children

Theme 3: Spiritual Coping

Religious coping may be among the most important factors determining QOL when people are facing a life-threatening disease (Atef-vahid *et al.*, 2011). However, many research studies exploring the impact of spiritual beliefs on coping with cancer are designed according to Western culture and mainstream religious Protestant and Catholic beliefs. The Protestant, Catholic, and Islamic religions believe that having cancer is God's choice. In the Protestant religion, the role of spirituality is to help a the woman cope with that which God has chosen her to have, and thus women with breast cancer embrace their suffering because it is a gift endowed by their God's love and grace. For these women, this feeling of choice is amazing and, even though they are unable to control their lives, their experience is one of gratitude and acceptance of their fate according to God's will. They feel they need to trust in God and their medical practitioners. Furthermore, they find peace and strength and a new meaning in life and death in their daily faith and practice regardless of whether they are Protestant or Catholic. In the Islamic religion, the words of Allah, which are expressed in the Qur’an, do not have the same meaning as they do for Catholics and Protestants. Therefore, the spiritual life of Muslims must be based on acts of worship and dictates living the religion as it is ordained in the Qur’an. In an Islamic context, religion constructs not only rituals but also an inner dimension which governs a 'way of life' that encompasses the political, social, and economic contexts (Ahmad *et al.*, 2011). Chinese and Taiwanese studies showed that such women believed in fatalism and felt they had no ability to change their outcomes regarding cancer. The findings were very different in the current research, as all of the participants believed that breast cancer was their 'own karma' reflecting poor thoughts and behaviours exhibited in a past life. Consequently, they could change their karma through Buddhist practice in the present, and a strong faith enabled them to achieve happiness and good success in their future life. They believed that they could overcome their problems. Four themes that emerged related to Buddhist coping were (1) transforming negative karma, (2) opening up one’s own Buddhahood, (3) fulfilling the Bodhisattva identity, and (4) hope and future. These are significant in explaining how Chinese cultural and Buddhist beliefs impact coping and cancer survivorship.

6.3 Section 2: Buddhist Coping

6.3.1 Buddhist Coping Theories of "the Oneness of Body and Mind"

Gautama Buddha explained the classification of the mind as including five aggregates: physical phenomenon, sensation, perception, mental fashioning, and consciousness (Kato, 2016). According to the Buddhist principles of ‘oneness of body and mind’ (shikishin-funi), the physical aspect (body) and the mental aspect (spirit) are two aspects of a single entity and each influences the other (Ikeda *et al.*, 2003). The Buddhist phrase of the ‘body and mind are two but not two,’ which means that the body and mind are interrelated, denotes the inseparability of spiritual and material manifestations (Ikeda, 2003). The oneness of body and mind is derived from the Buddhist term, *shiki shin funi*, and the oneness of life and environment is influenced by the ‘mutual possession of the 10 worlds’. The Chinese Buddhist scholar, Miao-lo, explains that appearance as it exists in the material and physical world represents the outward aspect of life, while the spiritual world is identified as the unseen inner element, which is the internal cause, and thus its appearance is a latent effect (Ikeda, 2003). This is the well-known Buddhist Ichinen Sanzen principle, which can be better understood as a scientific system representing the phenomena of the totality of life (Ikeda, 2003). Reciprocal elements thus influence each another in many aspects of psychology and physiology. For example, emotional stress and anxiety provoke physical changes in heart rate along with increases in blood glucose and hormones in the brain, which impact the efficacy of psychosomatic medicine. Positive sentiments such as joy and hope therefore activate and reinforce the body's immune powers (Ikeda *et al.*, 2003). Recently, the mind–brain relationship has been explored through scientific investigations in the fields of psychopathology and neurophysiology (Ikeda, 2003).

6.3.2 Coping Personality and Breast Cancer

Type C personality includes those who are passive, incapable of expressing their own emotions, and who focus on pleasing other people (Eysenck, 1991; Bozo, Tathan, and Yilmaz, 2014). The breast cancer survivors with type C personality characteristics may have higher levels of QOL if they perceive high social support interaction (Bozo *et al*., 2014). Type C personalities may exhibit a suppressed immune system that may not be related to psychoneuroimmunological processes (Bozo *et al*., 2014). What is psychoneuroimmunology? The first research published on this topic, in *The Lancet,* was carried out in the Centre for Psychoneuroimmunology Research and the Department of Psychiatry at the University of Rochester School of Medicine and Dentistry in Rochester, NY. Its focus was on behavioural–neural–endocrine–immune system interactions (Ader *et al.*, 1995). A relationship was therefore identified between alterations in behavioural and emotional perceptions and neuroendocrine changes (Ader *et al.*, 1995). For example, the death of a family member induces depression, which results in a decrease in the number of natural killer cells, T- and B-lymphocytes, and helper and suppressor/cytotoxic T-cells (Ader *et al.*, 1995). Thus, psychosocial factors and emotional states influence the development and progression of infectious, autoimmune, and neoplastic diseases (Ader *et al.*, 1995; Antoni, 2013).

The ‘first wave’ of psychotherapy focused on behavioural therapy in the 1950s, while the ‘second wave’ emphasised the use of cognitive behavioural therapy in 1970s and the ‘third wave’ involved mindfulness-based cognitive therapy and acceptance and commitment therapy to prevent major depression and/or the recurrence of such (Fung, 2015). Cognitive intervention in the form of optimistic rational appraisals may enhance psychosocial adaptation and improve longer-term health outcomes (Antoni, 2013). In this respect, revealing one's intrinsic nature power is strong and can enhance optimism, positivity, and a will-to-live spirit amongst cancer patients. This form of spiritual self-help therapy is based on the Buddhist concept of the oneness of body and mind and the Ichinen Sanzen principle. Furthermore, Dr. O. Carl Simonton's mind–body theory suggests that mental imagery can enhance the immune system's response (Simonton *et al.*, 1978; Holland and Lewis, 1995). Visual guided imagery can teach patients to envision the cells in their immune system as a legion of white knights on horseback vanquishing small, slow-moving creatures (the cancer cells), ultimately eventually winning the battle (Simonton *et al.*, 1978; Holland and Lewis, 1995). It is therefore fascinating and instructive to explore the mind–body interaction when coping with cancer.

Behavioural interventions can reduce anxiety, distress, and fatigue by teaching stress management skills and relaxation techniques (Antoni, 2013). Dr. Herbert Benson founded the Mind/Body Medical Institute at the Harvard Medical School in Cambridge, MA. He studied pre- and post transcendental meditation and found that the relaxation response amongst volunteers resulted in them consuming 17% less oxygen while meditating and that their breathing slowed down to approximately 10 or 11 breaths per minute (Benson, 1995). The psychologist Robert Keith Wallace and physiologist Archie F. Wilson conducted similar experiments in California on practitioners of transcendental meditation and found that brain wave patterns during meditation included low-frequency alpha, theta, and delta waves and high-frequency beta waves (Benson, 1995). Transcendental meditation involves the silent repetition of a sound, called a mantra, to minimise distracting thoughts, and the passive disregard of intrusive thoughts (Benson, 1995). The repetitive prayer produces the same physiological changes that were originally noted in transcendental meditation (Benson, 1995). Recently, the Massachusetts Medical Center developed a MBCR program and supportive–expressive group therapy to examine the effects of psychosocial programs on telomerase activity and telomere length maintenance in distressed breast cancer survivors (Carlson *et al*., 2015). New insight in this regard would thus elucidate the chanting effect and its relationship with positive reappraisal coping experiences.

However, there is no instrument in existence at this time that measures how participants use Buddhist ideas and practices in response to a stressful life event (Phillips *et al.*, 2012). There is therefore room for both quantitative and qualitative research to increase the understanding of the different dimensions involved including cultural, self-identity, and role functions in cancer care. Buddhist coping therefore offers a new concept with which to explore the existentialist meaning of being in qualitative research and can possibly form the basis of a new chanting therapy. Buddhist beliefs and the Eightfold Path practice can cultivate people who are focused on the present moment, thus facilitating the development of acceptance and commitment therapy both now and in the future.

Buddhist coping therefore promotes psychosocial adaptation through cognitive, behavioural, and social support (Box 4). Nichiren Buddhism, in particular, advocates purifying one's mind so that the living environment will become the pure land, and the good or evil in our minds will determine our living world (Ikeda, 2003). The Buddhist concept of the ultimate reality of life is the oneness of body and mind. Both the physical body (material) and the mind (spiritual) are indivisible and continuously operate at the level of phenomena. Therefore, we must understand women with breast cancer within the context of their worlds.

6.3.3 Quotes from Ikeda: Hermeneutic Interpretation of Buddhist Coping

"I am a Buddha. I refuse to give up.”

"The important thing is to always believe in the Mystic Law and to enter the powerful orbit of faith, practice, and study. Entering the orbit—the orbit of human revolution and of changing our karma—is the way to construct a life of good fortune and happiness that will endure throughout eternity."

(Ikeda, 2017, p.277)

Box 4: Women with Breast Cancer, A Summary of New Learning Experiences of Buddhist Coping

- New knowledge is generated by this study
- Survival experiences after 30 years of diagnosis
- Recurrence of experiences after 30 years of diagnosis
- Karma can be changed
- Experience of social isolation as a form of Buddhist meditation
- Experiences of daily chanting for more than one hour
- Chanting can initiate hope
- Chanting reduces thoughts of suicide
- Feeling peace and calm after chanting the Nam-myoho-renge-kyo
- Appreciating other SGI/Buddhist members' blessings
- Focus on the present moment
- Widowhood experiences in coping with breast cancer
- Experiences of mindfulness meditation over 45 minutes to focus on breathing
- Yes, I can manage my problem
- Helping others' experiences, through peer support groups, using the Buddhist faith
- Buddhist coping experiences of a survivor taking care of her dementia-afflicted husband
- The beliefs of Karma bypass the notion of the sick role
- Being a Bodhisattva involves multidimensional engagement with others
- To avoid the sick role by engaging in healthy role behaviour through voluntary work
- The 'seven-day dhyana' (deep meditation) was a pleasant experience
- 'Human revolution' implies changing yourself
- Discovering the life's meaning through the Bodhisattva of Earth
- Reorganise life priorities to help others learning Buddhism

6.3.4 How Do People Perceive Things? How Do They Apprehend the World?

The phrase ‘back to the things themselves”’means taking individuals back to the transcendental life of consciousness through the suspension of belief and thus making sense of its noetic–noematic experiences (Groenewald, 2004; van Manen, 2014). Galvin and Todres (2013) describe the essence of well-being as a lifeworld structure that encompasses physical, social, emotional, and economic well-being. This section will discuss the uniqueness of each women's lifeworld as a breast cancer survivor.

According to Gadamer, all knowledge consists of prejudice without method, such as the appreciation of the art object that is an immediate and private sense of personal taste (van Manen, 2014). Gadamer argued that textual hermeneutics must involve careful exploration of the text with openness and sensitivity to original and historical traditions and contexts (van Manen, 2014). For example, people might have different experiences (noesis: intention itself) with an apple (noema: intention object); Newton saw an apple as revealing the effects of gravity, Steve Jobs saw an Apple as a computer product. A manager may perceive an apple in terms of the Rotten (Bad) Apple theory, which stipulates that bad people do bad things and may further influence other people to be bad within an organisation. There is also a Latin proverb which states ‘the rotten apple injuries its neighbours’ (Ammer, 2013). Cancer is itself perceived as a bad apple in life. The sour apple might provoke the memory of the chemotherapy as it was lived in time and space.

As a further example, people either like or dislike the taste of sour and bitter lemon food; the taste may therefore elicit an immediate positive or negative personal historical experience. All of the women in this study described the chemotherapy stage as their most difficult time, akin to the taste of a sour apple in their life. Their day-to-day existence had been composed of suffering, and their consciousness focused on the side effects of treatment such as finding that food had acquired distinctive odours. When the cancer patient later smelt and ate some food (noema: intention object), the sour taste evoked their memories (noseis: intention itself) of the chemotherapy period and thus feelings of nausea, vomiting, and much suffering.

Awareness of this sense-making issue may enable nurses to understand the impact of nursing interventions on patient’s lives in terms of the things that matter to them most. All 10 participants described their suffering during the chemotherapy period and their fear of infection, which led to them feeling a sense of social isolation. Mobility suffering refers to a negative psychological adjustment to the situation (Galvin and Todres, 2013). When a person feels they are useless, they might experience feeling unable to change anything in a meaningful way (Galvin and Todres, 2013). For example, Betty felt she was unable to walk and had also lost her memory. She said that she was incapable and thought of suicide at that time. This was because she did not want to be a burden to her family. Thus, mobility suffering is a sense of one's identity as ‘I am unable’ (Galvin and Todres, 2013).

Husserl (1970) suggested a new way of experiencing a sense of natural being, one that is situated above the natural world (van Manen, 2014). For example, when Husserl was walking through the dried and fallen autumn leaves (noema: intention object) on the way home from his office, they rustled and crunched under his shoes, triggering a childhood memory response (noseis: intention itself) and unlocking secret treasures buried there (van Manen, 2014). For example, he remembered his childhood friend and how they used to play in these mysterious woods and how they had also built a hidden hut.

In terms of the current study, Chloe, Fanny, Helen, and Jane described the development of childhood personalities that were entrenched in their memories. Helen had felt she was inferior ever since she was small. Fanny said that her personal character was timid and shy. A positive relationship between stress and the development of breast cancer can be found in several personality traits including emotional suppression, depression, conflict avoidance, a repressive coping style, and uncertainty (Rice, 2012). These four participants were too scared to express themselves, a character trait nurtured since childhood. Furthermore, Chloe also expressed how her character was timid even when she encountered a minor incident. In the past, she would not voice her feelings and she was angry with that person, although she did not admit that orally and instead blamed others. This form of theoretical insight can help inform the selection of representative samples in the future.

6.3.5 Emotion-based Coping

Being overresponsive to emotional stress and having an inability to manage anger (so-called ‘keeping anger in’) might lead to aggressiveness and hostility, which could possibly have contributed to the risk of breast cancer (Rice, 2012).

For example, Jane came to Hong Kong when she was small and was an illegal immigrant. She did not dare to talk about this with others and was worried that others would consider her insane. Her perception of her breast cancer sickness was that it occurred after her marriage and was not related to her childhood stress. Social roles are the cultural means by which a person’s functional responsibility in his or her society is shaped (Burnham, 2014). Jane believed that her sickness arose from problems in the relationship with her husband. She did not want to tell others, as she did not want to her failure to become known. She stated she could not cope with her stress because of her introverted character. Jane's story also reflects the Chinese cultural aspect of fearing a ‘loss of face,’ where people seldom expose family issues to others.

In 1980, Arthur Kleinman, a cultural anthropologist of medicine, observed the sick role of the patient being played out in China (Burbham, 2014). Recently, research has abandoned the notion of the sick role and shifted its focus on to the individual’s identity and their experiences with the illness (Burnham, 2014). Women with greater psychological stress after breast cancer surgery and anxiety regarding the anticipation of malignancy could impair their immune system by reducing natural killer cell activity and thus allow cancer cells to proliferate (Janusek *et al.*, 2012). A traumatic experience might lead to an intense impact on all aspects of a woman’s lifeworld. In this study, all of the women refused to take the sick role. When these women changed their perceptions (Ichinen Sanzen), they found new meaning in their life (the Mutual Possession of the 10 Worlds). The Buddhist coping theory can thus be applied to survivors to help them to alter their perceptions (Ichinen Sanzen) of cancer.

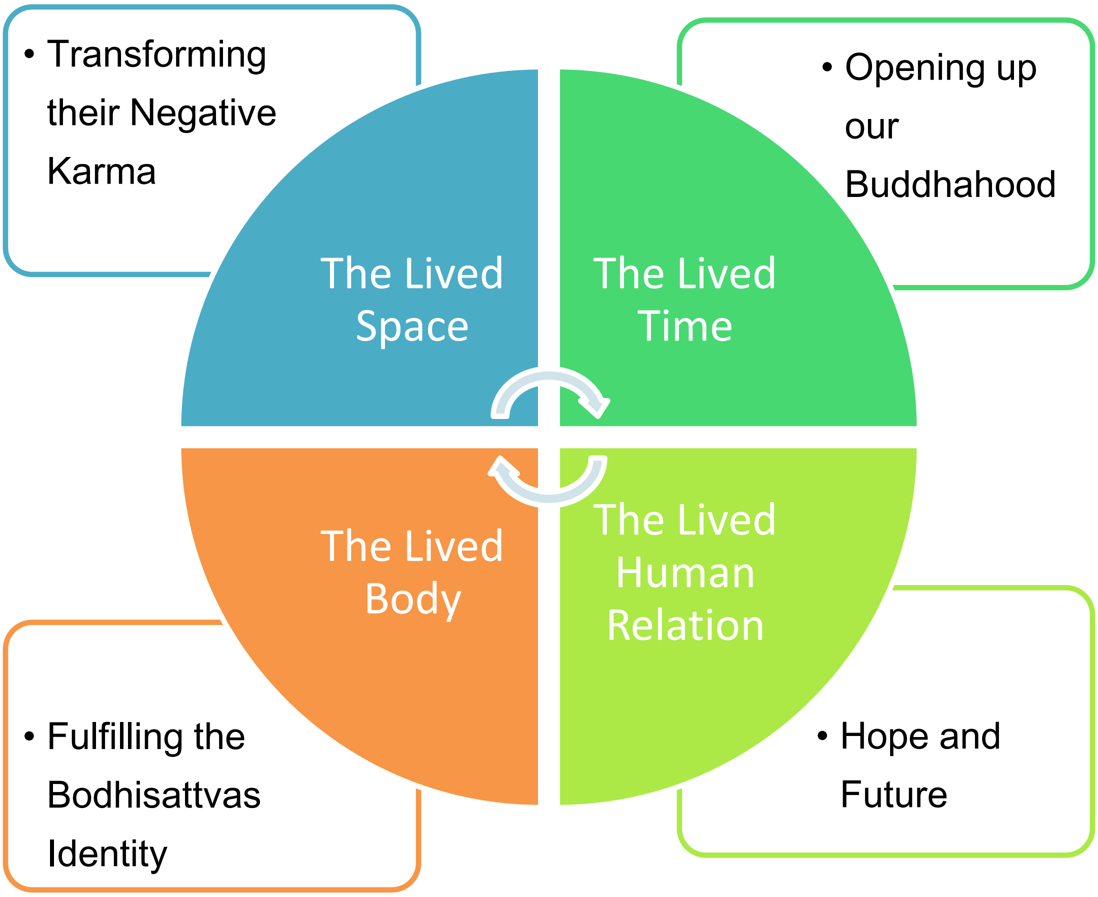


Figure 12: Four Buddhist coping themes.

6.4 Transforming Negative Karma

Gadamer (1994) explores the understanding of being and how this is formed through historical traditions. As a researcher, I attempted to lay the foundations of the hermeneutic circle in terms of its whole and parts. The participant's whole world of meaning can be understood only relatively. This included their experiences of self-understanding.

6.4.1 Karma-based Coping

Primary control coping includes direct action, planning, and seeking support to change the stressor, whilst secondary control coping facilitates acceptance, positive reappraisal, and fighting spirit (Kvillemo and Branstrom, 2014). There is now a new concept of karma coping that involves the engagement of coping strategies. For example, Amy, Dora, and Fanny had believed in Buddhism for many years, and they could not escape when the ‘karma’ came upon them. They continued reciting Sutra and prayed for a swift recovery. Jane believed in Buddhism after her diagnosis and was familiar with the new (to her) concept of ‘karma’. Her understanding meant that she was more willing to accept her husband’s financial situation, and she would not blame anything. After learning Buddhism, she focused on the problem-solving approach to settling her husband’s debts rather than committing suicide. Dora's story was a miserable one. Her husband passed away more than 20 years ago. Dora perceived her husband's death as an ‘impermanence’ in Buddhist belief. What impermanence refers to in this regard is that nothing permanent or unchanging can pass or transmigrate from one life to the next (Rahula, 1958). Dora described her personality as tough. Even though Dora had confronted many difficulties as head of a single-parent family, she refused to give up. She earned her living and brought up her two sons.

Most people accept the idea that effort (causes) produces rewards (effects), and many experience trials and tribulations in their life. In the Buddhist view, we each have our own karma. In short, the Buddhist law of cause and effect implies that the potential to change our karma is enormously increased by our Buddhist practice (Ikeda, 2003). Negative karma results in the unhappy life condition of human beings. Chanting to the Gohonzon every day will, eventually, change your karma at a fundamental level. Everyone can change their karma through action. Nichiren Daishonin encouraged their disciples to maintain their faith and attain Buddhahood in this lifetime, so that the Mystic Law enables them to overcome every obstacle (Ikeda, 2003). Buddhism thus helps the cancer patients to understand the reality of life under the law of karma (an individual’s destiny), which can be changed by accumulating religious merits (Lundberg and Trichorb, 2001). Furthermore, Ariyabuddhiphongs and Li (2016) found that, amongst 329 Thai female sex workers, giving was positively related to happiness and optimism. The Buddhist belief thus promotes the idea that good deeds (karma) return good results—for example, giving money to help other people results in optimism and happiness (Ariyabuddhiphongs and Li, 2016). Nine participants in the present study gave money to their Buddhist organisations to help to promote Buddhism.

How does Buddhism influence people who are facing life and death situations? The Buddhist concept of impermanence explains uncertainty in terms of karma-based coping (Phillips *et al.*, 2009; 2012). The transition from being a patient to being a breast cancer survivor is determined by the individual's attitude, faith, and culture (Swidler, 1986; Kaiser, 2008). Such findings address the spiritual and cultural concerns of Chinese breast cancer survivors. First, learning Buddhism plays a major role in their cancer coping journey. Second, prayer is the way to destroy all fear, the way to banish sorrow, and the way to light a torch of hope (Ikeda, 2009; Pun, 2013). Chanting the daimoku (Nam-myoho-renge-kyo) is to have faith in the Gohonzon, which establishes a life-state of indestructible happiness (Ikeda, 1995, 2016). Third, daily Buddhist practices and a positive commitment to giving are important, such as performing volunteer work to promote Buddhist activities. These findings were similar to those of Liamputtong and Suwankhong (2016), who found that women with breast cancer in Thailand accepted their fate and perceived their own karma as a meaning-making process, which further motivated their Buddhist faith and will-to-live for their children. These women did not feel angry and showed acceptance of their illness as an ‘impermanence’. An incredible journey enabled them to search for their ultimate goal in life. A health care professional should thus have a broad and comprehensive sense of how to help cancer patients cope with the physical, psychological, and social changes as well as the spiritual goals of the healing process.

6.4.2 Self-recognition of Enlightenment

Gadamer (1994) pointed out that ‘the mutual self-recognition in which the spirit is absolute can be attained only via confession and forgiveness’ (p.343). There is a process of enlightenment of personal identity that occurs when a person recognises 'I am a Buddhist' through self-reflection and change. For example, Helen actively listened to others’ experiences to achieve self-reflection and change. Separately, Gloria embraced her breast cancer survivor identity and understood her destiny could change through this sickness. All 10 women believed that karma and fate, from their Buddhist perspectives, could change by chanting the Lotus Sutra. This was because all women thought that the negative karma present implied something had occurred in their past lives. By tracing the women's Buddhist coping responses, I noted that the patterns that occurred involved accepting their situation and environment as an opportunity to transform their negative karma. They cherished what they had and showed gratitude for the support of other Buddhist members. For instance, Dora felt grateful to her masters and senior brothers and sisters in FGS, who were genuinely concerned and supportive of her.

As ‘I can’ signifies the person’s sense of identity, the action and attitude changes to being 'on the move', where each person feels able to change and develop their possibilities and self-beliefs (Galvin and Todres, 2013). Positive spiritual and religious coping reduced the study participants’ emotional distress and improved their QOL and physiological functioning. Chloe and Helen, for instance, felt the strength of the Buddhist beliefs, which assisted them. All six of the SGI women kept chanting very hard and thus they had a peaceful mind with which to accept the arrangement of ‘Gohonzon’. The three FGS women maintained the practice of meditation and thus they concentrated on focusing on the here and now. All of the women felt comfortable and calm after engaging in Buddhist practices.

These women’s cancer experiences served as a time for self-reflection and increased their faith. Most of the women developed new values and new meanings with which to restructure their lifeworld and initiate a positive change. These findings were consistent with other research findings showing that breast cancer patients have an increased appreciation of life and stronger interpersonal relationships (Garlick *et al.*, 2011). Furthermore, these women believed that their fate could change when they were continuously chanting the Lotus Sutra. There were, however, differences from other studies of Chinese women; in Cheng *et al.*’s (2013) study, for example, the 29 Chinese women who took part believed in fatalism and felt they were unable change their cancer outcomes. Conversely, in this study, the women initiated hope in a new life.

6.4.3 Wisdom-based Coping

The patients’ selection of coping styles was a crucial step, as they could select emotional avoidance coping to avoid a fearful mood or take a step forward and engage in a problem-solving and self-efficacy approach. How, therefore, do we initiate hope in cancer survivors? In the United States, Nezu *et al.* (1999) developed Project Genesis (funded by the National Cancer Institute) to assist adult cancer patients with constructing effective life plans. Through problem-solving therapy, cancer patients succeeded in coping with major life challenges and improving their QOL (Nezu *et al.*, 1999). Problem-solving models therefore help to diminish a patients' sense of helplessness whilst also promoting optimism, courage, and self-confidence (Nezu *et al.*, 1999). According to the patient's faith and culture, nurses can initiate hope and help them to set up short-term and long-term goals. Nurses can additionally encourage patients to construct effective life plans in their dairy where they can also detail their problem-solving progress.

The well-being experience is an ‘I can’ form of identity-mobility that constitutes an energised approach towards searching for the possibilities of the self (Galvin and Todres, 2013). When these women were confronted with their fate, they sought religious support. Existential psychology promotes the belief that positive meaning-making invites people to liberate themselves from being passive victims to becoming active and responsible participants (Liamputtong and Suwankhong, 2016). These women were forced to look at the meaning of their suffering and their purpose, or lack of purpose, in their life. In existential terms, they found meaning in their family and their role as mother rather than focusing on their health progress and prognosis. The essence of their life’s meaning is to keep helping other people including other breast cancer survivors. Best practices in nursing therefore involve actively engaging in the patient's search for life-meaning and promoting their self-efficacy. Furthermore, nurses can help the patient to develop a ‘yes, I can’ spirit through their religious power.

6.5 Opening Up Our Buddhahood: The Temporal Experience of Being and Time

How can ‘being' be understood? What is the meaning of being? Husserl argued that the transcendental ego was a form of ‘Absolute Being’ that bracketed out objects and acts (Collins and Selina, 1999). However, Heidegger insisted that being is always the being of something; thus being and time mean ‘there-being’ (Dasein) and being cannot be simply reduced to the body, the mind, and consciousness (Heidegger, 1988; Collins and Selina, 1999). For the participants, the waiting time was influenced by the perception of cancer until the tumour was removed from the body (Khatri *et al.*, 2012). Waiting was what stood between cancer and recovery; the key experience in each woman’s life was therefore that of waiting. The individual perception of time seems to speed up or slow down according to the state of their emotions and expectations. Turning points signified the awakening of the highest state of life—the Buddha state. Their true essence of life thus changed from passive to active action.

Gadamer said that ‘the classical, then, is certainly "timeless", but this timelessness is a mode of historical being’ (Gadammer, 1994, p.290). Within a person’s changing perceptions of past, present, and future, the meaning of time alters according to the context. This is especially true in the context of the fear and anxiety of cancer recurrence and being-towards-death, which allows the person to redefine meaning in their life (Khatri *et al.*, 2012). A sick role is a social act whereby an individual could give up normal functioning at work or home and also describes social behaviour and expectations (Burnham, 2012). A sick person at that time could receive a response of care and support (Burnham, 2012). The person diagnosed with cancer is acutely aware of time and, in an uncertain lifeworld, they do not take it for granted and therefore experience time as a precious commodity. The participants remember the dates and times of their diagnosis and chemotherapy and radiotherapy treatments, which become symbols of the disruption to the permanence of their lives. Furthermore, the participants’ recall of intricate details was extended to the details of test results, how many stitches they had, and so on, even with between 20 years and 30 years passing. These insights will prepare health professionals to guide discussions around the search for the meaning of Dasein and time is structured into care.

6.5.1 Meditation-based Coping

Temporal mobility refers to helping a person access memories and spatial mobility refers to helping a person go outside so that they can find their unique way towards well-being (Galvin and Todres, 2013). The purpose of 'mood-dwelling' refers to helping a person feel more peaceful in comfortable surroundings such as at home (Galvin and Todres, 2013). Galvin and Todres (2013) also pointed out that there is a form of suffering known as temporal unsettledness, which refers to a person who may feel unable to stand still and focus on the present moment. Most participants did not have this temporal unsettledness; they were able to experience sitting still and could focus on the present moment through meditation and chanting. Furthermore, they were able to open themselves to the world, an acknowledgement that life is involved with the world of things and persons. The 10 participants regained hope through the support of their family. They received encouragement from their family members, including husbands and siblings. There were two different ways participants who practised daily Buddhist rituals that opened up their mental state of Buddhahood to achieve a peaceful and comfortable mindset.

Six participants chanted the daimoku (Nam-myoho-renge-kyo). Nichiren Buddhism states that the deepest processes of change and purification take place when we bring forth this Buddhahood state, and their mentor, Dr. Ikeda, taught the practice of chanting ‘Nam-myoho-renge-kyo’ as a direct means of accessing and experiencing this state (Ikeda *et al.*, 2003). The life state of ‘Buddhahood’ is characterised by the qualities of compassion, wisdom, and courage. Chanting enables people to create something of value from any situation. Lazarus and Folkman (1984) explained this in psychological terms as a positive reappraisal of the stressor. The SGI women have therefore been adjusting to seeing their fate in a different light; they perceive the difficult moment and situation and seem more positive and grateful. Six women from the SGI practice chanted ‘Nam-myoho-renge-kyo’ every morning and evening, at which point, they felt comfortable and peaceful.

The three participants from the FGS group practised meditation every morning and evening. These self-practice participants chanted the Guan Yin Sutra. Again, it is interesting to note their changed perceptions of time (i.e., the past, present, future)—in most cases, there is a reorientation toward the present. Dr. Benson (1995) suggested that this process could be described as a relaxation response, a combined mind and body reaction. Dora, Iris, and Jane had all enjoyed such mindfulness experiences when meditating in the Amitabha Buddha Recitation

Session.

Transformation changes how we feel about and see the world. A Buddhist practice of the Eight Paths such as the Right View, Right Effort, and Right Mindfulness involves meditation that produces new insights that cultivate wisdom and compassion (Kramer, 2007; Fulton, 2014). Social isolation is perceived as a good meditation moment. The three participants of FGS had extraordinary experiences with meditation. Dora and Iris came to Taiwan every year to the seven-day meditation camp, which has a special meaning for them. The walking meditation allowed the members to walk in silence and feel every moment as a new chance and to cherish the present moment. Dora experienced her husband's death, which became almost part of her in the form of shadows that were beyond her conscious awareness. Comfort and discomfort and gains and losses were no longer significant to her. Dora saw no escape and chose to face up to them and continue her harsh life, transforming it into one of natural harmony. The FGS women practised their master's teaching using compassion meditation instructions.

6.5.2 The Mindfulness Effect in Facing Cancer

The MBSR was first introduced by Professor Jon Kabat-Zinn. MBSR is based on intensive training in mindfulness meditation and develops in continually changing internal states, enhancing the ability to cultivate moment-to-moment awareness by practicing mindfulness skills with patients who have chronic pain and stress (Bear, 2014; Fulton, 2014). When people suffer from anxiety and depression, they can become habitual negative thinkers. Mindfulness invites people to be open and to accept all experiences in their own way through a nonjudgmental attitude, patience, and kindness that is intentional and is the mode of the mind (Kuyken and Evans, 2014). The practice of mindfulness meditation can change our habitual beliefs and perspectives through focusing on breathing in and out, and so change the mind, thoughts, bodily sensations, and feelings (Kuyken and Evans, 2014; Shennan and Fenlon, 2011).

In Kabat-Zinn's book, *Full Catastrophe Living*, he introduces the MBSR programme, which includes a body scan and sitting meditation through to using the wisdom of your body and mind to face stress and illness (Kabat-Zinn, 1990). MBSR originated from the Buddhism theory of training in mindfulness meditation and produced significant research outcomes for patients with chronic pain and stress-related conditions (Bear, 2014). MBSR aims at cultivating moment-to-moment awareness through practising mindfulness skills which include an eating raisin exercise, mindfulness walking meditation, mindful yoga, and mindfulness in daily life (Kabat-Zinn, 1990; Bear, 2014). Kuyken and Evans (2014) suggested that mindfulness invited people to be open and to then shift gears between an automatic ‘doing’ mode of mind and an intentional ‘being’ mode of mind. The mindfulness process was open (to recognising the experience), accepting (the experience with a nonjudgmental attitude), and decentring (breaking up the patterns) (Kuyken and Evans, 2014). When participants were upset, most were able to recognise the experience (cognitive → affective → behavioural pattern) during Buddhist practice. The three FGS members (Dora, Iris and, Jane) practised sitting meditation every day; they consequently achieved a calm and peaceful mind. The Buddhist practices allowed their minds to become open and accept their experiences with curiosity, patience, equanimity, and compassion. Consequently, they could stop ruminating about their children's behaviours and themselves as a parent. Mindfulness broke up the patterning associated with their mother role. Their anxiety came from the uncertainty of death and knowing that they could then no longer take care of their children. Mindfulness focuses on staying in the present moment, with the experience, and finding perspective (decentring), for example by observing themselves breathing in and breathing out.

6.5.3 The Essence of Chanting

The clinical psychology field is changing with the ascendance of mindfulness and acceptance approach and their core assumptions are an awareness of and the relationship to thoughts (Hayes *et al*., 2013). Self as a context is an important changing process through meditation cultivating acceptance values, being present, and committing to action (Hayes *et al*., 2006; Hayes *et al*., 2013). All 10 participants took part in the Buddhist practice of chanting every morning and evening; they also reported having a calm and peaceful mind after chanting. In everyday life, we seldom reflect on our experiences of the here and now; however, many details regarding the meanings of moments will come back to memory. We name and describe the events or things and recall them, re-experiencing them through reflective awareness. Phenomenology involves a reflection and search for meaning in lived existence between the living now and the mediated now, which is already too late to capture (van Manen, 2014). For instance, this ‘now’ is the micro-moment of the glance of the blue eye or the macro-moment of living with depression. The macro-moment of living with depression may last for the now-duration of an hour, a week, a year, or even a longer period (van Manen, 2014). For example, Betty felt her treatment time lasted much longer than the actual time. This was because she felt suffering in her consciousness. Although Betty did not become involved in any Buddhist organisation, she chanted the sutra every day. She felt peace and comfort after chanting. This did not imply a strong or weak faith. Indeed, a change of mood indicates a desire to look at the past differently. The lived experiences of the meditated now have significant consequences, affecting present and future ‘being and becoming’ and, thus, the emphasis of Buddhist meditation regarding happiness is always on the here and now. After chanting the Buddhist Sutra, all 10 participants described experiences whereby their mind became calm and significantly comforted. For example, Gloria recited the Lotus Sutra and chanted for three hours every day. These women believed that their negative karma was attributable to their thoughts, words, and actions in the past. Each was the creator of their own life, and they would take the responsibility to create it after chanting. All 10 participants seldom adopted defence mechanisms including avoidance, withdrawal, and disengagement.

The Buddhist perspective of coping focuses on problem-solving and seeking social support and involves elements which emphasize taking direct action to change the situation and plan for future contingencies (Tyson and Pongruengphant, 2007). The Buddhist coping responses used here involved an active problem-solving approach that was oriented to reality, with the participants having studied their life mentor's teaching and received the necessary guidance. They chanted a great deal of daimoku (Nam-myoho-renge-kyo). For example, the six participants of HKSGI were inspired by the Lotus Sutra and, therefore, the problem in this instance was pointing out how important it was not to look outside yourself. ‘You are the problem. You are also the solution.’ (Martin, 1995). They were praying for the determination to accomplish their purpose in life. Furthermore, they had sought the solution to the problem within themselves and would not blame other people. This was because the Buddhist theory explains that the problem is ‘me’ rather than ‘you’. When people lose the Buddhist perspective, they start looking outside of themselves, blaming others, or thinking the problem resides elsewhere. The participants were chanting daimoku in front of the Gohonzon with the prayer, ‘Give me the wisdom to know what I need to do. Give me the wisdom to know what action I need to take’ (Martin, 1995). It was an inwardly-directed prayer rather than outwardly-directed, which reflects differences in the dimensions of actions. When the survivors assessed their own ability to cope, they focused on what they could do to overcome the difficulty and suffering. When taking a closer look at the women's explanations as to why they responded in the positive ways that they did, they had found their ultimate victory in life was to become a Buddhist. All of the women in this study believed that all misfortunes and ill fates would change into good fortunes, and then they will continue to have the ‘yes, I can’ fighting spirit and attitude to beat their disease.

After the participants’ chanting of the Lotus Sutra, they cultivated this ‘Yes, I can’ spirit, which was similar to Simonton's ‘will-to-live’ philosophy. In 1970, Simonton, a radiation oncologist, observed that the more positive the attitude of the cancer patient was, the greater their life expectancy and the lower the number of side effects—even though they were administered the same dose of radiation as others with a similar type of cancer (Simonton *et al.*, 1978). In the study, the 159 patients diagnosed with terminal cancer were expected to survive for 12 months;

nevertheless, 63 patients lived for up to 24.4 months, owing to the emotional support provided by the teaching of the ‘will-to-live’ philosophy (Simonton *et al*., 1978). Simonton thus promoted his ‘will-to-live’ philosophy in terms of a mind–body connection when fighting cancer (Simonton *et al*., 1978; Holland & Lewis, 1995). This philosophy incorporates detailed Simonton techniques such as relaxation and the mental imagery visualisation process, all presented at his cancer-care clinic in Pacific Palisades (Simonton *et al*., 1978). Lifestyle counselling also doubled patient survival time and could be attributed to the feelings of being in control rather than hopelessness (Simonton *et al*., 1978). A primary appraisal consists of a value judgment, while a secondary appraisal considers what could in fact be done (Lazarus & Folkman, 1984). Thus, value clarification, purposeful priority setting, and purposeful problem-solving may also be beneficial techniques for individuals suffering from negative life-changing events (Werner *et al*., 2012).

6.6 Fulfilling the Bodhisattva Identity: The Inner Transformation Process

What is of significant meaning to these women? The role and meaning of faith and the role of the Sangha were dominant factors in enabling these women to cope. Their meaning of life was focused towards actualising their essence of life and studying and practicing their Buddhist faith, as was evidenced by the selected quotes from the data analysis. All of the women used their religious support, including belief in the divine and prayer, as a coping tool regarding treatment decisions and as the basis of wishful thinking for the future.

Three behavioural principles for Buddhists to follow should be to perform good deeds by giving, to avoid evil deeds through the observance of the Five Precepts (sila), and to purify one’s mind through meditation (Ariyabuddhiphongs, 2009; Ariyabuddhiphongs and Li, 2016). However, there is a new and additional behavioural pattern present in Kosen-rufu designed to bring happiness to others. For instance, Amy was a strong advocate of Kosen-rufu because she believed that the unfortunate fate could be transformed through chanting, thus creating happiness for everyone. Kosen-rufu suggests the concept of people vowing to spread the Lotus Sutra widely by chanting the daimoku of Nam-myoho-renge-kyo.

The role of self-evaluation requires a conscious self-awareness of our experiences and that current and future situations may produce any emotion in our minds (Leary and Tate, 2010). The self-discrepancy theory developed by Rogers (1954) and Higgins (1987) posits that people sometimes experience discrepancies between their expectations of the actual self and the ideal self

(Leary and Tate, 2010). To minimise such self-discrepancies, people may perform their role duties and responsibilities successfully (Leary and Tate, 2010). For example, Gloria's ego of 'being and time' focused on her Bodhisattva identity. When Gloria bracketed out her household, family, and children, she spent all of the time taking on the role of a female leader in SGI activities for Kosen-rufu. Gloria's 'actual self' was her mother role, and her 'ideal self' was her leader role in SGI. Gloria's consciousness intended to chant the Nam-myoho-renge-kyo to achieve a purified, disembodied ego process. A self-actualisation process, as embodied in Maslow's hierarchy of needs, is oriented towards psychological well-being and growth (Schmutte, 2013). Gloria focused on a form of self-actualisation, which Maslow termed 'peak experiences', to move toward the self-fulfilment of her potential strengths.

A sense of identity-dwelling and identity-mobility is a form of well-being experience (Galvin and Todres, 2013). Six of the participants of SGI reported that religious support was essential in facilitating awareness of their inner Bodhisattvas identity. Gloria was bad-tempered in the past, and her human revolution experience implied changing her attitude and behaviours. She realised the real cause of happiness was mercy. Gloria believed that every person had their own ability to solve a problem. This was illustrated in coping patterns where certain forms of behaviour were encouraged; this was Kosen-rufu, which means widely spreading the Lotus Sutra. The second Soka Gakkai President, Josei Toda, described the individual inner transformation process as one of 'human revolution' (Soka Gakkai International, 2017). Human revolution involves self-discipline and applying an effort that could enable everyone to make a positive change. The women thus started to behave differently. Their Buddhist faith gave them the willpower and, therefore, the self-control and self-discipline that would enable them to have a more positive attitude towards life. This is a well-being experience of 'mirror-like' multidimensional fullness and a mood where one feels complete and nothing is missing (Galvin and Todres, 2013).

6.6.1 Compassion-based Coping

Dr. Hans Selye postulated that living a constructive life was to feel respect and sympathy, to set goals for yourself and to live for the benefit of others (Ikeda *et al.*, 2003). A constructive life for Bodhisattvas is to live for the peace of humankind (Ikeda *et al.*, 2003). As SGI members come to realise their being and belonging (identity) as Bodhisattvas of the Earth, they will spread the Lotus Sutra. Ikeda (2016) introduced the idea that the Bodhisattvas of the Earth are people who ceaselessly work to spread the Lotus Sutra; they are always moving forward in achieving Kosen-rufu and world peace. Revealing one's intrinsic nature means illuminating and making manifest the true nature of all phenomena (reality) through the wisdom of the Buddha; in other words, the fusion of wisdom and reality. In Thai culture, Buddhist merit and merit-making stems from the view that almsgiving is a good deed that will provide strength and lead to less suffering in life (Liamputtong and Suwankhong, 2016). There is thus a different concept in SGI philosophy of the Buddhist merit to be the Bodhisattvas of the Earth, which is Buddhist merit-making through the spreading of the Lotus Sutra.

6.7 Hope and Future

What is the true essence of happiness? Happiness is no guarantee, even if you are wealthy, famous, and healthy. The great Russian author Leo Tolstoy (1828–1910) declared that, ‘happiness is found in gladly fulfilling one's life purpose’ (SGI President Ikeda's Editorial, 2016, p.4). Furthermore, happiness is to be found in carrying out one's mission while bravely making one's dreams come true. All of the participants indicated that the most essential support came from their faith, which was a critical ingredient for their physical, psychological, social, and spiritual well-being. The Buddhist coping pattern involves gaining strength and power from the Buddhist faith and the support it offers. There will be future happiness in life if hope is maintained.

Although these women had to experience the suffering of sickness, they focused on their future goals. Their mission was helping other people. Elsa sought to chant daimoku for suffering people who had experienced unfortunate incidents. She prayed for peace, getting rid of disasters, happiness, avoiding earthquakes, and obtaining a stable home as soon as possible. This is when the human being is tuned into the sense of merely being, a well-being focus on ‘being there’ and thus a focus on connectedness through care for others (Galvin and Todres, 2013). A person at this point achieves self-actualisation, develops altruism, and appreciates what is happening around them, thus facilitating a greater self in the sense of ‘I am’ (Schmutte, 2013).

Hope for the future and a need to take care of others may be a development of spiritual well-being. As a member of FGS, three of the participants would continue their Bodhisattva practice of compassionate giving such as carrying out volunteer work and donating money to FGS Buddhist organisations. Dora's was a heart of compassion similar to that of Bodhisattva because she hoped that other patients did not suffer and were free of pain, even when they experienced surgery similar to hers. Iris also expressed her wish to be a nun in the next life. Her word ‘echo’ was a unique Buddhist term which meant transferring her Buddhist merits towards blessing other people and hoping for world peace.

6.8 The Pattern of Buddhist Coping

In coping with fears of recurrence, positive reappraisal was the common coping response. Through prayer, the women used both cognitive strategies of emotion-focused coping and behavioural strategies. They believed that Buddha would provide them with the wisdom and courage to find the resources needed, enabling them to cope with the side effects of treatment. All 10 participants expressed the view that they should refuse to be defeated by any negative situations or influences. None of them feared breast cancer recurrence and death, choosing instead to focus on the present moment and how to help others. All women stated they would continue their study and practice of the Buddhist faith so that they could transform bad karma into good karma in the future. They had a strong sense of gratitude towards the people helping them in their recovery journey. For instance, none of them placed any blame on others; they were accepting of rather than denying toward being a breast cancer patient. The six SGI members felt that adversity was an honour for practitioners of the Lotus Sutra. In accordance with their faith, they highlighted the importance of dedicating one's life to the Mystic Law and the great vow for Kosen-rufu, which enabled them to lead successful lives.

‘Understanding here is always application’ (Gadamer, 1994, p.309). According to the Buddhist theory, there are six broad categories of Buddhist coping resources that can be used to interpret and make sense of stressful situations. First, people should have the right attitude to impermanence and remember that no stressor will last forever. People should also engage in social interaction with compassion and heart, which means showing empathy and being nonjudgmental of the self and others. Second, karma-coping can be applied where stress is believed to result from one’s past actions or when considering the consequences of one’s actions (Phillips *et al.*, 2012; Abu-Raiya and Pargament, 2015). Third, people are interrelated, which incorporates interbeing (recalling that everything is connected when dealing with stress), dharma (obtaining Buddhist information through readings or conversation), and not-self (there is no element of the self that is permanent) (Phillips *et al.*, 2012; Abu-Raiya and Pargament, 2015). Fourth, the right understanding is applied to the phenomenon. This involves attempting to view the world as it truly is and avoiding ‘delusions’. The right understanding concept refers to having the wisdom to comprehend the world if one has inaccurate perceptions of it that lead to suffering (Abu-Raiya and Pargament, 2015). Fifth, the other themes are meditation (a nonjudgmental focus on a specific stimulus—e.g., the breath, a mantra) and mindfulness (attending to whatever was occurring in the moment, whether it was a particular thought, emotion, or environmental circumstance). Finally, the idea of spiritual struggles means that there are challenges and difficulties involved in sustaining a spiritual life (Abu-Raiya and Pargament, 2015). Consequently, Buddhist disciples should practice morality (following moral behaviour including practicing the right speech, right lifestyle, and right action) and should find support (social and spiritual) in one’s Sangha (Abu-Raiya and Pargament, 2015).

Action was central to an individual’s future karma (Coderey, 2015). All of the participants had engaged in two patterns of behaviour: to actualise the essence of life and to study and practice their Buddhist faith. The bodies and minds changed from passively ‘being helped by others’ to more actively ‘empowering and encouraging other people’. Their actions were focused on helping the breast cancer support service and encouraging other women who had suffered from the same disease. They also promoted public awareness of breast cancer risks and encouraged other people to undergo a regular body check. The NGO of breast cancer support groups thus assists cancer patients and peer support groups in helping each other accept their emotional distress. The survivors act as a support network to give support to the other women as if they were in the same boat.

Changes to priorities in the lives of breast cancer patients are common phenomena in the recovery journey. The present findings are echoed by those of other literature including new life perspectives, personal growth, and enhanced relationships with family (Cheng *et al*., 2016). Nine participants retired and only Fanny had continued to work as a private tutor and insurance agent. Interestingly, retirement is also associated with better QOL, which is interpreted as that they have more time to construct a sense of meaning of the illness (Bovero *et al*., 2016). For instance, breast cancer survivors often develop a strong commitment to helping other women (Sampoornam, 2015). All of them had passion for their voluntary work in the Buddhist organization and expressed their strong determination to promote Buddhist activities in the community. The strong faith and family understanding this engendered became a source of hope and a form of empowerment for participants during their cancer trajectory. They continued to learn from Buddhist teachings and sustain the practice of chanting, both morning and evening. They felt they had an obvious mission to engage in 'Kosen-rufu'. They helped other breast cancer patients by telling them their stories and carrying out voluntary work in SGI organisations. SGI members supported each other, for instance, in prayer and in chanting the daimoku to sick people, as an accompaniment to hospital and treatment processes. Dora, Iris, and Jane were happy and had no regrets about their lives. They felt love and support from their family and the senior brothers and sisters in their Buddhist organisations. Betty's actions were through self-practice in chanting the Guan Yin Bodhisattva Sutra and Life-extending 10-line Kannon Sutra. Betty continued to carry out volunteer work in the TSCA helping other cancer survivors. Voluntary work and giving are thus good actions that induce good karma (Coderey, 2015).

Strong family support was the 'key' to generating hope and future engagement. Furthermore, they felt energised in their mission to fulfil their mother role within the family and take care of their children. All participants reported that the support of family and friends helped them achieve their highest level of happiness. Their husbands were supportive throughout, accompanying them to follow-up sessions and assisting with the household chores.

Lazarus and Folkman's (1984) coping model focused on both positive appraisal emotions and altering the environment, believing that all factors were interdependent and exerted a mutually reciprocal effect (Hollon and Beck, 1979;

Lazarus and Folkman, 1984). All of the participants indicated that the most essential support came from their faith, which was a critical ingredient for their physical, psychological, social, and spiritual well-being. These women were therefore more likely to express emotion through praying and chanting the Lotus Sutra, following which they were able to engage in wishful thinking and problem-solving. The Buddhist coping pattern involves gaining strength and power from the Buddhist faith and the support it offers. There will be future happiness in life if hope is maintained. These religious support systems provided the women with strength and encouragement. The participants mainly focused on solving their problems and placed great emphasis on the entry point at which feelings, thoughts, and actions were changed by Buddhist beliefs and meditation. In Thailand and Canada, palliative hospital nurses utilize meditation and relaxation to help dying patients and their relatives to cope with stress (Tyson and Pongruengphant, 2007). This study can contribute to the body of knowledge in nursing and inspire new insights for nurses in meditation and relaxation.

6.9 Section 3: Implications and Recommendations

6.9.1 The Original Contributions Made to the Knowledge-base

This study adds to our understanding of the lived experience of cancer and religious/spiritual coping in the Hong Kong setting - the first of its kind. The other studies have explored religious and spiritual coping in relation to cancer experiences, but mostly in the Western context. Before focusing on the more conceptual and theoretical contributions, it is important to highlight the findings and the construction of the four Buddhist coping themes: transforming negative karma, opening up to Buddhahood, fulfilling the Bodhisattva identity, and hope and future. These common themes are central to understanding the contribution of the thesis to new knowledge. The participants demonstrated spirits of 'yes, I can' and 'I am a Buddha, I refuse to give up.' The phenomenological way of looking at experiences is not only seeing the content and the value in description, but also attempting to understand what causes certain behaviours to show and the level of explanation of the effect of such causes (DeRobertis, 1996). For example, the clearest understanding possible of what it really means to swim and what does the meaning of swimming in a particular person as a different existence (DeRobertis, 1996). Gloria, one of the participants in my study, stated that swimming was important to her journey of recovering from cancer and her strong body helped her to spread the Lotus Sutra and the Kosen-rufu in the community. Indeed, the Buddhist faith and the related coping phenomenon were recommended in the cancer journey of the people who faced the challenges of this illness. The spiritual dimension signifies the person's sense of identity, so the actions, behaviour and attitude changes to being more 'on the move', where each person feels able to change, to grow, and to develop their possibilities and self-beliefs (Galvin and Todres, 2013). Positive spiritual and religious coping approaches reduced their emotional distress and improved their self-reported wellbeing and physiological functioning.

Methodologically the thesis has provided an analytical contribution building on previous work, for example - the two-layer data analysis method. The first layer of data analysis is followed the process of TA as described by Boyatzis (1998) and Braun and Clarke (2006). The holistic approach involves reading the text as a whole to identify emergent themes (Reiners, 2012). The second layer of data analysis follows the process of phenomenological reduction as described by van Manen (1990). This selective approach extracts essential statements pertaining to the lived body, lived time, lived space, and lived relations (van Manen, 1990; Reiners, 2012). I therefore engaged in a reflective process to utilise the hermeneutic circle method of analysis, which was under continual review (Reiners, 2012; Johnson, 2016). Common themes were identified between the participants' individual thematic maps.

In terms of the theoretical contributions, I creatively applied Gadamer's hermeneutic fusion of horizon approach in understanding Buddhist coping in relation to breast cancer survivors' experiences. Gadamer (1994) explored the understanding of being and how it is formed through historical traditions. As a researcher, I attempted to lay the foundations of the hermeneutic circle in terms of its whole and parts. The participant's whole world of meaning can be understood only be piecing together the parts of their experience (and in relation to the whole). This was also an important contribution included taking into account their chanting experiences of self-understanding of well-being.

Theoretical contributions also include new ways of thinking about the five stages of loss and grief as described by Kübler-Ross, stages that the participants had did go through. These stages included denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969; Boerner, 2008). Amy and Chloe felt that they were not prepared for 'total hair loss' and selected to wear a wig, while others preferred to 'be natural' and go bald. We should emphasise that the transition from being a patient to being a breast cancer survivor is determined by the individual's attitude, faith, and wider culture (Swidler, 1986; Kaiser, 2008). Buddhist coping is the actualization of self-care resources. The participants quickly accepted their situation (loss of hair, breast) and did not blame others or self-blame. How does Buddhism influence people who are facing life and death situations? The Buddhist concept of impermanence explains uncertainty in terms of karma-based coping (Phillips *et al.*, 2009; Phillips *et al.*, 2012).

6.9.2 Implications for Nursing and Cancer Survivorship

The Hong Kong Breast Cancer Registry Report (2017) revealed that the most common risk factors for breast cancer were lack of exercise (less than three hours per week) (77.7%), no breastfeeding (65.8%), being overweight (38.6%), a high level of stress for more than 50% of time (37.1%), and no childbirth/first live birth after the age of 35 years (26.2%). One-third (33.5%) of the 14,905 patients reviewed had four or more risk factors (HKBCR, 2017). There may therefore be a common problem regarding decreased awareness, strong cultural barriers, and a lack of regular breast cancer screenings (Al-Azri *et al.*, 2014). Health education is therefore important in promoting cancer risk awareness and in encouraging healthy lifestyles. A meta-analysis showed that clinical breast examination had a sensitivity of 54% and a specificity of 94% (Ying, 2011). Nurses can act as significant advocates for breast self-examination and mammography screening. To provide nursing education for cancer prevention is important, especially in primary health care settings.

In the UK, the National Cancer Survivorship Initiative was developed to help people receive the care and support they need to lead a healthy and fulfilling life, with a focus on wellbeing and a holistic understanding of each person's requirements. The National Comprehensive Cancer Network collaborated with over 1,000 clinician experts to develop evidence-based guidelines for cancer care (Spinks *et al.*, 2012). Sales (2010) stated that the UK's National Health Service had designed more than 600 survey instruments to measure user experience, all of which were available in a patient-reported outcomes and QOL database. Chopra and Kamal (2012) conducted a systematic review of 19 studies evaluating QOL instruments in long-term breast cancer survivors. The results found that all four domains (physical, psychological, social, and spiritual) of QOL were outcome indicators. Patient-reported information found that their major concerns are regarding QOL, fatigue, anxiety and depression, physical activity, work ability, and cosmetic satisfaction (Young-Afat *et al*., 2017).

In the National Cancer Patient Experience Survey (2015), more than 80% of respondents gave positive responses (Quality Health, 2016). For instance, 90% of respondents were assigned a named nurse as a clinical nurse specialist, and 87% said that it was very easy to contact them throughout their treatment (Quality Health, 2016). As some patients personality are reluctant to discuss symptoms, the specialist oncology nurse has a role in providing supportive care to help patients build up the feelings of confidence and normality. For example, people with type C personalities were defensive in response to stress and demonstrated the suppression of negative emotions and the inability to cope with interpersonal stress; as a result, they often felt hopeless and helpless and had a tendency to give up rather than fight (Eysenck, 1991). Cognitive behavioural therapy and social support were effective in reducing a cancer patient's anxiety and depression and in improving their QOL (Todd, *et al.*, 2014, Spiegel and Giese-Davis, 2003). It is important for health care professionals to be more proactive in being culturally sensitive, considering a patient's values and beliefs. Furthermore, nursing interventions focus on increasing patient knowledge to facilitate self-efficacy coping strategies and enhance adaptation and rehabilitation regarding the disease process, treatment, and side effects (Shockney, 2011; Petree, 2016; Merluzzi *et al.*, 2018). Consequently, the role of the clinical nurse specialist is important in providing holistic care in recovery and palliative care throughout patients' cancer journeys. Macmillan Cancer Support has designed self-management interventions for cancer survivors that incorporate seven steps, as follows: a needs assessment plan, intervention typology, theoretical framework, intervention delivery, intervention techniques, implementation plan, and evaluation (Gao and Yuan, 2011). The UK's National Cancer Survivorship Initiative helps people live well with cancer, while the breast cancer charity organisations the Haven and Penny Brohn provide free information and mind–body therapies to cancer patients (Hoffman *et al.*, 2012). Holism implies in palliative care education that human systems have an innate wholeness about them that is more than the sum of their parts (Teal *et al.*, 2018). The SCNCP suggested nurses facilitate a holistic care approach in caring for life-limited cancer patients and family by searching ways to improve their peace and comfort as well as sense of well-being (Teal *et al*., 2018). The advanced holistic nursing approach looks for ways to use complementary modalities for the promotion of spiritual healing in the mind, body, and spirit (Teal *et al*., 2018). Thus, nurses should address both physical and psychosocial aspects whilst also maintaining holistic concerns regarding the impact on family, work, and patients' spiritual well-being. Interpretive phenomenological research findings can thus assist Hong Kong nurses in providing more sensitive, patient-centred, and holistic care through an interpretation of their patients' faith and lived experiences.

Previous research has demonstrated the beneficial effects of religious coping. However, there is no consistency among the different types of spiritual coping used for psychological well-being at this time (Kvillemo and Branstrom, 2014). There has been little in the way of research exploring how Chinese speaking women with breast cancer use religious coping. This underlines the significance of this study in providing information on how Chinese cultural and Buddhist beliefs impact coping and cancer survivorship.

The foundation of well-being lies in maintaining health, harmony, and self-transcendence to achieve the most of one's ability (Healey-Ogden and Austin, 2011). Well-being is associated with greater social networks and social support (Kroenke *et al*., 2006). If the breast cancer survivors are socially isolated from friends (hazard ratio: 4.06; 95% confidence interval: 1.40–11.75) or living children (hazard ratio: 5.62; 95% confidence interval: 1.20–26.46), they had increased risks of mortality (Kroenke *et al*., 2006). The posttraumatic growth subjectivity indicators are strongly associated with a better appreciation of life, which revealed positive changes in future altruism (Lelorain *et al*., 2012). Altruism is the more significant source of happiness and the ‘firmness’ of a Bodhisattva (Yang *et al.*, 2015). Chanting is a mantra recitation process designed to transform your loving-kindness mind to altruism (Wayment *et al*., 2011). Wayment *et al*. (2011) promoted a quiet ego construct of well-being or happiness that cultivates empathy, wisdom and altruism through mindfulness meditation of the Buddhist practitioners. Helping others act as part of a supportive–expressive group therapy, which leads to having a better happiness, is beneficial. The seeds of well-being can be planted in being, being-with-others, and being-in-the worlds in a creativity of altruism (Ikeda *et al*., 2003; Heidegger, 1962). Nurses could promote the understanding and care through the Mandala of Health model and nurture well-being altruism experiences where the self and the world become one (Hancock, 1993; Healey-Ogden and Austin, 2011). ‘The more Bodhisattvas that enter the community, the more pure altruism that will dominate the population.’ (Yang *et al*., 2015, p.346). Suggestions can therefore be made regarding the determination of a baseline religious coping strategy that will help predict future outcomes such as the correlation between emotional and physical health. Details of these are provided in Box 5.

Box 5: Recommendations

Recommendations

For the General Public

To promote the awareness of cancer screening

To promote healthy lifestyles

In Health Care Policy

To provide financial support in patient care for targeted therapy and chemotherapy

To establish and provide an active network of breast cancer survivors

To promote religious coping in cancer care in different settings

In Clinical Practice

To facilitate self-efficacy and ability to self-care

To respect the patient's lifeworld-led approach, which includes their cultural, traditional, and religious rituals and practices

To encourage a mind–body and holistic approach to nursing care

To create a supportive environment using complementary alternative therapy

In Research

To explore the mind–body impact of Buddhist coping

To explore other types of meditation such as chanting

In Patients and Survivors

To encourage a spirit of never giving up

To encourage love, tolerance, and openness to their problem

To search for meaning and purpose in their lives

6.10 Strengths of the Present Research

The aims of this study were (1) to explore the experience of living with breast cancer by investigating patients’ knowledge, understanding, perceptions, and experiences of their disease and (2) to understand the impact of Buddhist religious and spiritual beliefs on Chinese women who have survived breast cancer. An in-depth literature review facilitated an exploration of breast cancer experiences, survivor's identities, and religious coping. A consistent and rigorous methodology was employed, which was transparent in its approach and involved a systematic (step-by-step) analysis (Meyrick, 2006). Transparency provides the reader with a clear disclosure of all relevant research processes including sampling and the data collection process. Reflexivity ensures rigour in terms of revealing any biases and the assumptions on which they are predicated as well as a detailed explanation and interpretation of the research findings (Meyrick, 2006). Moreover, the original framework of this study lay in the foundations of a Gadamerian–hermeneutic–phenomenological methodology that was used to understand Buddhist coping in cancer experiences. Consequently, it provides an original contribution to the body of knowledge in the health care professions.

Oncology nurses and other health professionals helping cancer survivors in both Western and Eastern cultural settings may benefit from the new knowledge about Buddhist coping generated in this study. This study also has practical implications for nursing care, especially regarding holism, client empowerment, and posttraumatic growth in searching for the meaning of life. Buddhist coping provides new insights for nurses and raises awareness of the client's religious power and support in their cancer journey. This study advocates a commitment by nurses to a ‘lifeworld-led care’ approach, which involves caring for and understanding a human being as a whole person. The caring attitude should be given more attention within a psychosocial, spiritual framework rather than in physical care interventions only. A well-being perspective thus strives for acceptance and a problem-solving approach to coping.

A ‘never give up’ spirit further emphasises the importance of the patient’s available social support and religious resources. The value of spiritual empowerment defines their life purpose in expanding the self towards helping other people, which promotes the potential strengths of a human being. The religious resources used require conscious learning of Buddhist teaching and practices. The grateful heart is the key to tapping the merits of Buddhism. This study therefore provides a valuable point of reference for nurses to understand the needs of breast cancer survivors in their different recovery journeys. Furthermore, the knowledge generated from this study may benefit the public in raising awareness of stress and effective coping responses in daily life events. The awareness of regular cancer screening is also important, such as the self-examination of breasts and the use of mammograms. Finally, the study advocates financially supported and targeted therapy policies and cancer screening in society. Policymakers and service provider organisations need to be more sensitive by providing bespoke services and holistic care to different groups of religious and ethnic people in Hong Kong. In this sense, there should be more attention paid to formulating health care policy with regard to religious and spiritual issues when designing community cancer care.

6.11 Limitations of the Present Research

This research paradigm was interpretive in that the Buddhist beliefs guided the researcher and provided the framework within which the participants' perspectives were understood. Thus, thoughts and ideas were viewed through the lens of Buddhist historical traditions. These Buddhist beliefs might be taken for granted and seemingly invisible, but should be understood as a set of rituals and feelings about the world. The interpretative paradigm thus shaped an understanding of what constituted the essence of the truth from a Buddhist perspective. Hermeneutics emphasises how prior understanding and biases shape the interpretations made in data analysis of texts and meanings (Gadamer, 1994; Denzin and Lincoln, 2003). The Buddhist coping concept of the whole and the part can itself be understood only in relative terms.

> *'The whole of meaning that has to be understood in history or tradition is never the meaning of the whole of history' (Gadamer, 1994, p. xxxv).*

However, there are a few limitations within this study. Participants' recall of events was relied upon even up to 30 years after surgery. Being-in-the-world changed the meaning of temporality. It was important to understand the level of threat experienced by the participants. This could help them reframe their view of the future. The effect of this previous life experience resulted in the 'care' structure being construed differently and this shaped my understanding of the impermanence of being (Heidegger, 1962). Cancer disrupts the normal balance including role functioning so that time is split between before and after diagnosis and is full of uncertainty. The participants provided rich and detailed accounts.

Even though they were elderly—for example, Gloria was aged 69 years and Elsa was aged 80 years and they had 26 years and 35 years of survivorship experience, respectively—they did not appear to have any trouble with recall. This was because neither of them had received chemotherapy. Betty, on the other hand, with just four years of survivorship, was suffering from the memory loss associated with the chemotherapy period.

There are perhaps difficulties in recruiting informants whose faith is weak as well as negative Buddhist coping informants. This was because of defamation the Buddha, which resulted in bad karma in the eternal life cycles. All participants demonstrated strong faith and performed daily practice. Furthermore, the parameters of the research did not facilitate the recruitment of upper social class participants, only lower and middle social class participants. Their living environment, which sometimes includes conditions of poverty, perhaps represents the experiences of most of the public in Hong Kong. Significant stress and problems arise from financial burdens to the family. However, the participants with Buddhist beliefs did not exhibit self-blame strategies, which is quite different in comparison with recent research conducted in Western countries. For example, McClean (2005) argued that the self-blame theme reflects a sense of individual responsibility and raises a significant concern for political and health beliefs, both in the UK and in the US. There were no deviant cases in this research where the Buddha and their Buddhist faith were blamed during the cancer journey. People preferred to exert self-control and self-mastery. Personal responsibility and individual accountability for health is perhaps overemphasised, resulting in the neglect of contributory factors such as environmental conditions and poverty (McClean, 2005). There is expected to be a new direction in the form of a holistic approach towards complementary alternative medicine (McClean *et al.*, 2012).

Regarding Buddhist beliefs, there are many different schools and forms of practice; this study only offered a small sample size, in which survivors came from the Nichiren Buddhism, FGS, and self-practiced Guan Yin schools only. The findings could not, therefore, be deemed representative of the entire Buddhist faith, nor other faiths or non-faith breast cancer survivors.

6.12 Future Research

Koenig (2014) asked ‘does religion help?’ in patient care. Most research has tended to focus exclusively on Caucasian populations (Kwok and White, 2014). Little information has been gained about the needs of Chinese-Australian breast cancer survivors, who have found that they experienced cultural and linguistic isolation in situations where English is the dominant language (Kwok and White, 2014). The stories of Asian breast cancer survivors are therefore a clear source of interest in the nursing field. Moreover, there is also room for further narrative and phenomenological research to be conducted in Chinese and Asian cultures. Nichiren Buddhism chanting, for example, may be a form of meditation whose method is the repetitive prayer of the Nam-myoho-renge-kyo mantra. Furthermore, there will be new and potentially different Buddhist coping experiences occurring in other ethnic and racial groups. Future research, both quantitative and qualitative in nature, could focus on exploring other forms of meditation associated with Nichiren Buddhism, such as the chanting effect.

6.13 Chapter Summary

The advances in cancer research are focused on the holistic care of cancer survivors in order to enable them to achieve their physical, psychosocial, and spiritual needs. The hermeneutic circle was applied to understanding the 10 participants’ meanings underlying their cancer experiences as Buddhists. The four Buddhist coping strategies included karma-based coping, wisdom-based coping, meditation-based coping, and compassion-based coping. These findings can inspire new clinical nursing practices and policies for understanding and caring for someone with the Buddhist faith. The strengths and limitations of the study were then considered and suggestions were made for future research.

Chapter 7: Conclusion

7.0 Introduction

This chapter revisits the aims and objectives of this study, which were achieved and supported by the key findings. New knowledge of the four Buddhist coping themes and patterns introduced to the knowledge base are linked to women's health with the coping experiences and cancer survivorship.

7.1 Quotes from Nichiren: The Power of Nam-Myoho-Renge-Kyo

‘Nam-myoho-renge-kyo is like the roar of a lion.

What sickness can therefore be an obstacle?

What is most important is that,

by chanting Nam-myoho-renge-kyo alone,

you can attain Buddhahood.

It will no doubt depend on the strength of your faith.

To have faith is the basis of Buddhism.’

Nichiren Daishonin

(The Writings of Nichiren Daishonin, WND-1, 412)

7.2 Revisiting the Aim of the Study and the Key Findings

A cancer diagnosis is a life changing event, and the impact of breast cancer disrupts daily lives in multiple ways. Religion and/or spirituality in the form of private or collective beliefs, practices and orientations, can provide a means to cope with stress that comes with illness and uncertainty, along with the fear of recurrence. There is, however, little in the way of research on this subject in the context of the Buddhist faith as much of the existing research is focused on Western settings. This study sought to explore the spiritual impact of Buddhist beliefs on women's lived experiences of breast cancer survivorship in Hong Kong. The research question posted was:

How do Buddhist beliefs impact the lives of women with breast cancer?

This study aimed to determine the spiritual impacts of Buddhist beliefs on women's lived experiences of breast cancer survivorship in Hong Kong. Their unique lifeworld stories reflected the wider context of health care in Hong Kong. The interview and interpretations of the data were conducted in Cantonese and Chinese.

One study objective was to explore the lived experiences of women with breast cancer. The Heidegger interpretive approach that was applied revealed phenomenological aspects of the participants' lives including being, being-with-others, and being-in-the-world. Data collection lasted for 14 months and new knowledge generated from the shared themes listed, as follows: (1) the suffering was more serious than words could explain; (2) I was grateful; (3) I would try my best to think of others; and (4) I am a Buddhist.

A second study objective was to learn more about the role of Buddhist religious beliefs. Buddhist coping is significant in promoting the will-to-live motivation rather than fatalism in the situation of the surrounding fear and uncertainty crisis. The Gadamerian hermeneutic circle facilitates the appropriate interpretation and deeper understanding of meanings. The hermeneutic circle was applied to explain the 10 participants' meanings underlying their cancer experiences as Buddhists. Furthermore, the new essence of Buddhist coping in the lived experience of the participants included the following four main themes: (1) transforming their negative karma, (2) opening up their own Buddhahood, (3) fulfilling the Bodhisattva identity, and (4) hope and future. These findings can inspire clinical nursing in better understanding and caring for someone with the Buddhist faith.

An unexpected finding was to understand their survivorship in terms of self-identity; those who accepted their 'new self' after treatment showed the most important factor in their life was the responsibility of motherhood. The mother's role is 'being and belonging', the most cherished identity of all participants, and the household chores and duties could help in alleviating painful and stressful moments and enable them to be more appreciative of their lives. Furthermore, the women found the sense of deep self-efficacy that comes from marital relationships. For how a husband and wife made their Buddhist way over life's rough places together, the essential ingredients are a sense of gratitude and a common goal of Kosen-rufu (meaning in p.xix).

The original contributions suggested that Buddhist coping be considered in caring for the cancer survivors to initiate hope, where previously none such recommendation had existed despite their 'lifeworld' essences of chanting and meditation. There is a growing evidence-based support regarding how patients and care providers increasingly have used complementary and holistic therapies in cancer nursing care. The advanced practice nurses can promote some mind-body practices including the MBCR program, yoga, and tai chi exercise in their practices to manage patient acute and chronic disease (Williams *et al*., 2015).

The value of spiritual empowerment defines the life purpose in expanding the self towards helping other people, which promotes the potential strengths of human beings. Although Elsa (aged 80 years) and Gloria (aged 69 years) were the older people in this study, they are still empowering because of their SGI Bodhisattva identity. This shows importantly that empowering old people with cancer can motivate them to choose a new role function. The religious resources used require a conscious learning of Buddhist teachings and practices. Their intention of gratefulness was not only a prospective predictor of spiritual well-being but also a key to tapping the merits of Buddhism. This study, therefore, provides a valuable point of reference for nurses to understand the posttraumatic growth of appreciation of life in their spiritual change journeys.

Chanting and meditation were examples of mobility-dwelling that could initiate hope and optimism. Surprisingly, little information is available concerning the use of such at various stages of the inner transformation process in stressful cancer survivorship. The spiritual self-care workshop/ retreat had a significant positive impact to address patient's spiritual concerns, compassion care and spiritual self-care skills; however, few health care professionals had received training (Anandarajah *et al*., 2016). Furthermore, breast cancer patients and survivors' online health communities can help people to foster an improved coping ability, social support, and combat loneliness (Smith *et al*., 2016). The nurse–patient relationship could also meet the religious faith and spiritual needs of survivors who have found peace, hope, and new meaning in their recovery. Therefore, a multimodal care approach can provide either face-to-face or online services including acceptance and commitment therapy as well as mindfulness and hope interventions to help individuals and couples become empowered regarding their spiritual well-being and self-care ability.

7.3 Conclusion Summary

The new insights into Buddhist coping concepts presented herein are invaluable to the nursing field concerning how they influence the stress, appraisal, and coping processes undertaken by breast cancer survivors. Health care professionals can encourage cancer patients to redefine their ultimate goal in life to achieve happiness uniquely. Buddha is life itself. You are Buddha now.

8. References

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10. Appendixes

A: Audit Trail of the Literature Search

Audit Trail of the Literature Searches

1. First search: Date: 1996 - 2013

Religious faith AND Breast Cancer

n= 14610 results

(Include: Book/e book: 10437, Journal article: 3703, Magazine: 440, Book Chapter: 153)

Religious faith AND breast cancer AND Coping

n=7401

(Include: Book/e book: 5727, Journal 1608, Book Chapter: 68)

Phenomenology approach and breast cancer

n = 3287

Breast cancer AND spiritual healing

n = 273

Spiritu* AND cancer

n =95

Religio* AND cancer (abstracts read/scanned)

n = 47

Religio* AND breast cancer AND women experiences (abstracts read/scanned)

n = 13

n = 9 rejected, n= 4 of use

1. Nelson (1996)
2. Lam and Fielding (2003)
3. Al- Azri *et al.*, (2009)
4. Johnston, (2012)

2. Second search: Date: 31/12/2003 to 1/6/2013

Search in EBSCO and CINAHL Plus	2003-2013
Key words	Results of Journals
First searching in 3/10/2013	
Phenomenology approach & breast cancer	3287
Phenomenological research	434
Phenomenological research & breast cancer	13
Breast Cancer & spiritual healing	273
Spiritu* & cancer	95
Religio* & cancer	47
Buddhis* & cancer	3
Buddhis* and breast cancer	1
Breast Cancer & Asian	12
Breast Cancer & Chinese	20
Breast Cancer & Hong Kong	1
Second Searching in UWE website 26/12/2016	2005-2016
Religious faith & breast cancer survivors	1278
Religious faith & breast cancer survivors & coping	886
Buddhist coping in nursing	390
Buddhist coping & breast cancer	114
Buddhist coping & breast cancer survivors & Chinese	48
Buddhist coping & breast cancer survivors & Hong Kong	0

3. Completed October, 2018

Source: 1/10/2015- 1/10/2018 (date limit)
EBSCO 1/10/2018
PROQUEST 1/10/2018
ASSIA: Applied Social Sciences Index and Abstract
Social Services Abstracts 2015-2018
Sociological Abstracts 2015 -2018

Key terms no date limit
Cancer AND Faith
n = 1982

Date limit: 1/10/2015- 1/10/2018
Cancer and faith: 308 results
Breast Cancer AND Faith
n = 111
Cancer with filters applied (to exclude: genetic, children, screening, education, quantitative studies, lesbians and men's health)

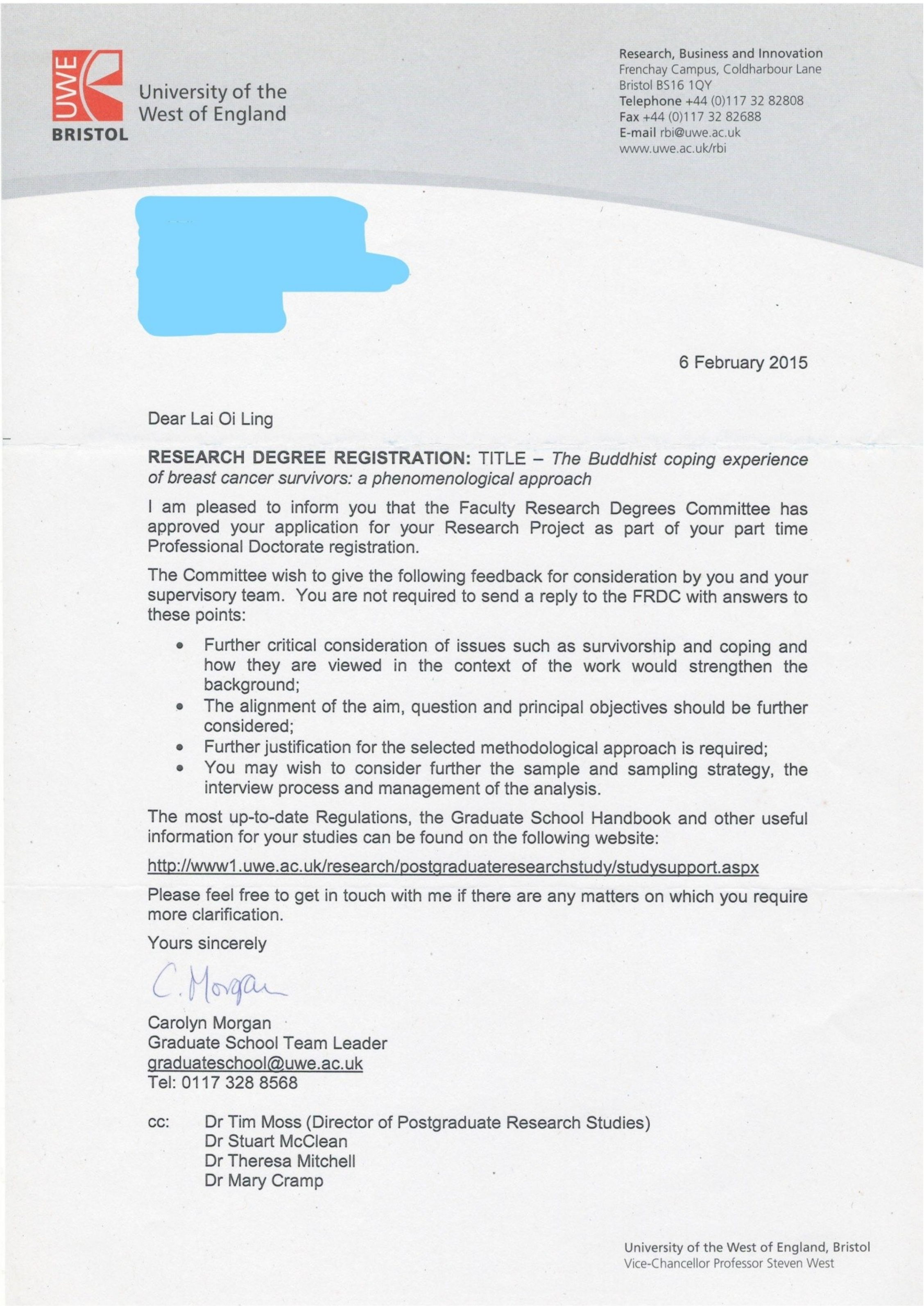
Breast cancer and faith of screening: 36 results

n = 36 abstracts read/scanned
n= 25 rejected (reasons: quantitative/treatment/screening/education related)
n = 5 rejected after further scrutiny (reasons: experiences of health workers or nursing students/ palliative care)
n = 6

5. Cheng *et al*., (2013)
6. Sampoornam (2015)
7. Barthakur *et al*., (2016)
8. Chen *et al*., (2016)
9. Ahmadi *et al*., (2016)
10. Jimenez-Fonsecal *et al*., (2018)

EBSCO no duplicates
Total number of papers of use n = 10

B. Research Degree Application Approval



UWE
BRISTOL
University of the
West of England

Research, Business and Innovation
Frenchay Campus, Coldharbour Lane
Bristol BS16 1QY
Telephone +44 (0)117 32 82808
Fax +44 (0)117 32 82688
E-mail rbi@uwe.ac.uk
www.uwe.ac.uk/rbi

[redacted]

6 February 2015

Dear Lai Oi Ling

RESEARCH DEGREE REGISTRATION: TITLE – *The Buddhist coping experience of breast cancer survivors: a phenomenological approach*

I am pleased to inform you that the Faculty Research Degrees Committee has approved your application for your Research Project as part of your part time Professional Doctorate registration.

The Committee wish to give the following feedback for consideration by you and your supervisory team. You are not required to send a reply to the FRDC with answers to these points:

- Further critical consideration of issues such as survivorship and coping and how they are viewed in the context of the work would strengthen the background;
- The alignment of the aim, question and principal objectives should be further considered;
- Further justification for the selected methodological approach is required;
- You may wish to consider further the sample and sampling strategy, the interview process and management of the analysis.

The most up-to-date Regulations, the Graduate School Handbook and other useful information for your studies can be found on the following website:

http://www1.uwe.ac.uk/research/postgraduateresearchstudy/studysupport.aspx

Please feel free to get in touch with me if there are any matters on which you require more clarification.

Yours sincerely

C. Morgan

Carolyn Morgan
Graduate School Team Leader
graduateschool@uwe.ac.uk
Tel: 0117 328 8568

cc: Dr Tim Moss (Director of Postgraduate Research Studies)
Dr Stuart McClean
Dr Theresa Mitchell
Dr Mary Cramp

University of the West of England, Bristol
Vice-Chancellor Professor Steven West

C. Ethical Application Approval

Faculty of Health
& Applied
Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16
1DD
Tel: 0117 328 1170

UWE REC REF No: HAS/15/06/177

8th July 2015

Ms. Lai oi ling

Dear Kathy

Application title: The Buddhist coping experience of breast cancer survivors: A phenomenological approach

Your ethics application was considered by the Faculty Research Ethics Committee and, based on the information provided, has been given ethical approval to proceed with the following conditions:

1. Information Sheet: Please check information sheet for accuracy, for example the following is missing a word: *"It is important to hear what*

people from a Buddhist beliefs background have to say about being a breast cancer coping in their survivorship in Hong Kong".

If these conditions include providing further information please do not proceed with your research until you have full approval from the committee. You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at http://www1.uwe.ac.uk/hls/research/researchethicsandgovernance.aspx. Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: http://www1.uwe.ac.uk/aboutus/departmentsandservices/professionalservices/marketingandcommunications/resources.aspx

The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.
2. You must notify the University Research Ethics Committee if you terminate your research before completion;
3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

We wish you well with your research.

Yours sincerely

Julie B Woodley

Dr Julie Woodley

Chair Faculty Research Ethics Committee

c.c *Stuart McClean*

D. Consent Form

University of the
West of England
BRISTOL

Thank you for your reading the following consent form.

Title: The Buddhist coping experience of breast cancer survivors: a phenomenological approach

1. I confirm I have read and understood (or other people read and explain) the above participant information sheet and I have a copy for retention.
2. I have opportunities to raise the questions and queries so that I can understand my risks and benefits of participation in the research study.
3. I agree to take part in the project. Taking part in the project will include being interviewed and audio recorded.
4. I understand my participation is voluntary. I can withdraw from the study at any time and I do not have to give any reasons for why I no longer want to take part.
5. I am willing to provide my name and contact telephone number in order to follow up investigation. I understand all my personal details such as phone number will not be revealed to people outside the project.

6. I understand all my providing information which will keep confidential and anonymous.
7. I understand that my words may be quoted in publications, reports, web pages, and other research outputs.

Interviewee's Name:

Signature:

Contact telephone numbers:

Date:

Investigator's Name: Lai oi ling

Signature: Lai oi ling

Contact telephone number: 92403344

Date:

E: General Risk Assessment Form

University of the West of England
BRISTOL

GENERAL RISK ASSESSMENT FORM

Ref:

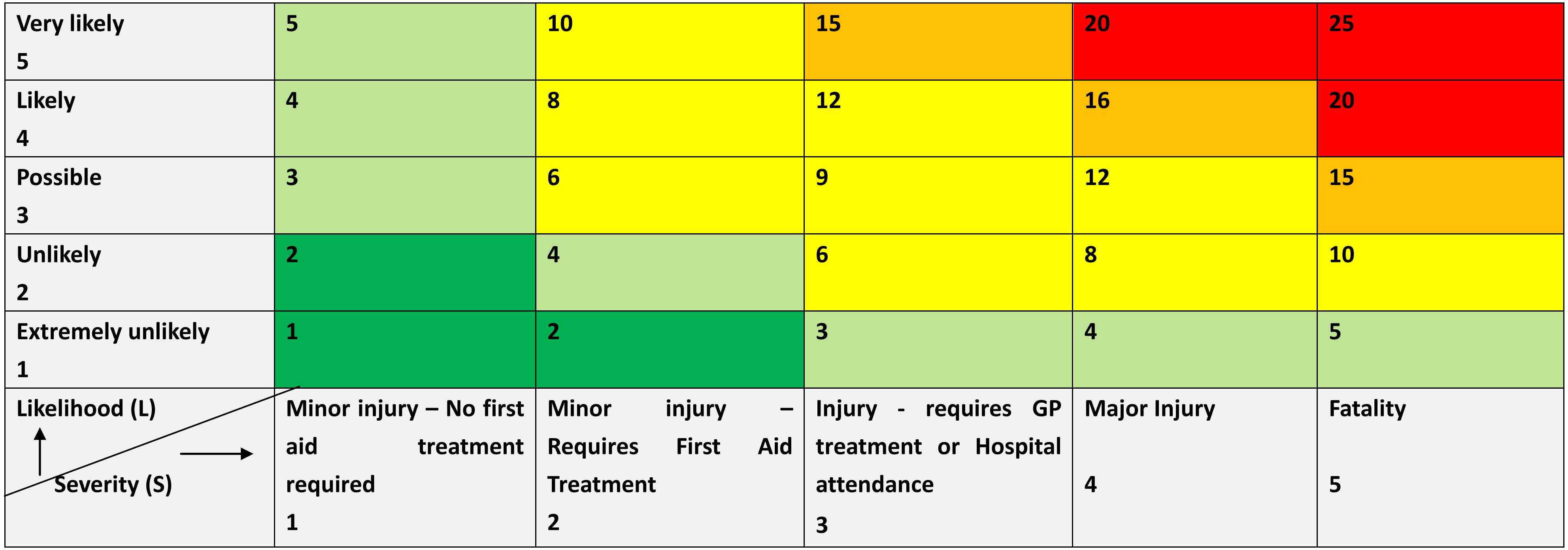
Describe the activity being assessed: The researcher will ensure the participant's health and safety during the face to face interview. The procedure will follow the Health and Safety Committee of the UWE established standards and guidelines.	**Assessed by:** **Ms. Lai oi ling** **Student No: 12970406**	**Endorsed by:** **Dr. Stuart McClean** **Dr. Theresa Mitchell**
Who might be harmed: the research participants (may be up to ten women and 20 interviews) and the researcher's own safety **How many exposed to risk:** 20	**Date of Assessment:** **Interview period from 1/7/2015 to 30/10/2016**	**Review date(s):** **Finished all the interview 1/7/2015-30/10/2016**

Hazards Identified *(state the potential harm)*	**Existing Control Measures**	**S**	**L**	**Risk Level**	**Additional Control Measures**	**S**	**L**	**Risk Level**	**By whom and by when**	**Date completed**
1. The participants may become upset or discomfort during interview	1. The researcher will ensure that risk assessment take place at the beginning of the interview. 2. The researcher will proceed carefully and allow the	1	2	2	1. According to the local situation, the researcher will have the responsibility to take reasonable care of the health and safety of the interviewee and will	1	1	1	The researcher will have the risk assessment all the time	30/10/2016

	participant to proceed with the interview at their own pace. 3. The researcher will be sensitive to responses and if the interviewee become upset and allow them the opportunity to close the interview or continue. 4. The researcher will make sure it is a safe place to discuss sensitive issues and she will explain the confidentiality in process.				provide an appropriate counselling services if needed.					
2. The researcher will need to ensure her own safety and well being.	1. The researcher will seek the detailed information of the places of the interview in order to reduce risks to her health and safety	1	1	1	1. The researcher will ensure that have performed the risk assessment at the planning stage of any research process proceed. 2. The researcher will report all accidents, incidents to	1	1	1	The research will report to her supervisors as the research	Until finished the study 30/10/2016

					her supervisors which will use the established reporting arrangement of UWE.				process and reflect on this.	

RISK MATRIX: (To generate the risk level).



Very likely 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Extremely unlikely 1	1	2	3	4	5
Likelihood (L) ↑ Severity (S) →	Minor injury – No first aid treatment required 1	Minor injury – Requires First Aid Treatment 2	Injury - requires GP treatment or Hospital attendance 3	Major Injury 4	Fatality 5

ACTION LEVEL: (To identify what action needs to be taken).

POINTS:	**RISK LEVEL:**	**ACTION:**
1 – 2	NEGLIGIBLE	No further action is necessary.
3 – 5	TOLERABLE	Where possible, reduce the risk further
6 - 12	MODERATE	Additional control measures are required
15 – 16	HIGH	Immediate action is necessary
20 - 25	INTOLERABLE	Stop the activity/ do not start the activity

F: Transcript of Participant 8 (Helen) second interview

K: Researcher, P8: Participant 8

1. K: I have invited Ms. Chan, patient 8, to accept a second interview. She has signed a consent form. I would like to ask if your Buddhist belief has assisted you.
2. P8：I thought it helped me a lot. It enabled me to enhance the positive strength and to overcome every difficulty. I felt less pain. I accepted myself no matter whether it was good or not. I accepted whatever happened to me.
3. K: What were the difficulties for you? Could you please give an example?
4. P8: In fact, I felt I was inferior since I was small. I lacked confidence. Chanting daimoku enhanced my confidence. If I encountered something that I was not able to handle, I would accept my failure to do it. I prayed and hoped and I continued to put in great effort and proceed every day. There was a hope that I could achieve the target in the future.
5. K: Could you please tell me what you targeted to do? Could you give an example?
6. P8: In fact, I intended to bring up 4 children. I hoped that they placed trust in “Gohonzon” and were able to overcome the obstacles. Their lives were moving forward. They could grow up happily.
7. K: The motivation for curing the breast cancer was to look after your 4 children. Was that what you meant?
8. P8: Yes, it was. I thought my greatest mission was to bring them up and look after them. They grew up healthily and happily.
9. K: You underwent medical treatment for more than 3 years. How did you feel during this time?

10. P8: I kept making progress. Due to this sickness, I found that everything could be achieved on the condition that you placed trust in “Gohonzon”. It depended on whether you were willing to put in the effort and were willing to do it. I stepped up my efforts to overcome the difficulty and bear the hope. I should not grumble. I could achieve the target if I continued to put in the effort.
11. K: You talked about your belief in “Gohonzon”. You thought that the impossible turned to possible. Was that what you meant? Could you please give an example? Thank you.
12. 4:27 – 8:46
13. P8: Yes, I thought that the impossible could turn to possible. If you were willing to put in the effort and were willing to change, you could achieve the target.
14. K: Anything related to your sickness?
15. P8: I had been so frustrated that I thought of committing suicide. I intended to give up and did not want to be a burden to others. However, I was strengthened through chanting daimoku, and visits from sisters, my mother and different SGI members. There were supports from different people such as neighbours and other patients. They gave me encouragement. Some also had trust in Buddhist teachings and “Gohonzon”, especially Mrs. Lau. I recalled her words. She assured me that I would recover and witness the success of my 4 children.
16. K: Could you please tell me the process in which you were frustrated and thought of suicide at the beginning and then changed to regaining confidence? How did you change your mind? Please explain. Thank you.
17. P8: The change of my mind was caused by the encouragement of my

younger sister and the experience of Mrs. Lau. The only way was to chant. I truly trust the words of Mrs. Lau. She gave me the hope to move forward.

18. K: Could you please talk about the difference between before and after chanting? Did you chant whenever you felt frustrated?
19. P8: Whenever I felt frustrated or hopeless, I chanted in my heart. This made my mind more peaceful and I viewed the incident with a positive perspective. I avoided taking a negative perspective.
20. K: As you felt peaceful after chanting, could you please talk about what your positive emotions and negative emotions were?
21. P8: The negative emotions were being angry with people, the incident and myself. I was angry and asked myself why I could not do well and why I was not as capable as others. I built positive emotions through chanting. I thought it was good enough as long as I paid the efforts and did my best. I did not mind other results.
22. K: Please give an example of whom you were angry at, or what incident you were angry at. Alternatively, how were you angry at yourself?
23. P8: Who made me angry? I was angry at the person who blamed me. I was angry at myself as I was not doing as fast, well and smart as others. In other words, I wanted to improve further.
24. K: In what sense were you not as fast as others? You were a housewife. Was it related to your past work experience?
25. 8:47 – 12:47
26. P8: It was about the relationships with others. For example, how to talk to children in a way that the children would be more willing to obey? I only scolded them. I should learn how to talk in an indirect way. I should control my emotions well.

27. K: It was related to how you teach your 4 children. You thought you were inferior to others as you were not as capable as others in nurturing the children. Did I misinterpret your meaning?

28. P8: I was not as capable as other mothers. I expected the children could achieve better academic results and other aspects if the mothers possessed the knowledge to teach them.

29. K: Did it make any difference after you chanted?

30. P8: Chanting enabled me to find out that it was my problem. I focused on studying gradually and improved my communication skills. I avoided speaking in a negative tone as this was harmful to the children.

31. K: You found out your weakness through self-reflection. Then you learnt and changed your behaviour. Was that what you meant? Could you please tell us what you studied?

32. P8: What did I study? My younger sister gave me some readings. I read a great variety of books. I also attended lessons and talks. I listened to others' experiences to achieve self-reflection and change.

33. K: You mentioned that your younger sister and other SGI members paid visits to you. Could you please share with us the details of these visits?

34. P8: My younger sister liaised with the Women's Division. She also believed in 'Gohozon'. She paid me a visit and chatted with me. She showed support and assured me of peace. She shared with me that other SGI members with cancer had a positive future.

35. K: As you went through the treatment for breast cancer, did you think the medical, religious or confidence factors assisted you in your recovery from the sickness?

36. P8: All factors contributed to my recovery. Medical, doctors and technology

certainly helped. My religious belief cured me with "changing from poison to medicine". My confidence was based on an optimistic view. Happiness was a good medicine.

37. 12:48 - 16:45
38. K: Could you explain the meaning of "changing from poison to medicine" please?
39. P8: In Western medicine, chemotherapy and targeted therapy were similar to arsenic, which were poisonous in nature. It cured the cancer with poisons. Through chanting, I hoped the treatments managed to fight against the cancerous cells.
40. K: You thought you were optimistic. Did Buddhist teachings have influence on your optimistic outlook or not?
41. P8: Yes, it did. “Gohonzon” had an influence on my optimistic attitude. I prayed that the worry would turn to good. There would be a good ending after going through the difficulty.
42. K: What did you think was the result of those worries after you chanted and prayed?
43. P8: The result was it became smooth. I felt relaxed.
44. K: The Buddhist belief enabled you to maintain a peaceful mind. You prayed about your worry. The result was positive, wasn’t it?
45. P8: I prayed that every incident was good for me. I enjoyed the process. I did the best every day.
46. K: You did the best every day. You focused on the present instead of the past and future. Could you talk about this please?
47. P8: Yes, sure. My mentality was to focus on doing the best for the present. I was unable to predict the future. I treasured and enjoyed the present.

48. K: Fine. After the surgery, your body changed. Did the Buddhist teachings affect your view?

49. P8: The change of body? The Buddhist view? Yes, I read from a book that everyone was equal. I did not feel inferior. Chanting provided me with the positive view and avoided the negative view.

50. 16:46 – 20:31

51. K: That's fine. You spent 3 years undergoing treatment, from 2012 to the present. Did you think the time had passed slowly or swiftly? What did you feel about the time during this period of your life?

52. P8: I thought the time had passed swiftly. 3 years had passed. I should bear hope in life. I treasured and was grateful for every incident and person.

53. K: You thought the time passed quickly. You were grateful to people around in your heart. Was that what you meant? Would you please elaborate and talk about it? You had a disease and you were hospitalised. Did you think the time had passed swiftly or slowly when you thought about the process again?

54. P8: I felt that hospitalisation was slow. I was grateful to the doctors, nurses and maids. Each of them helped me a lot. I was grateful to everyone who saved my life.

55. K: For example, while you were at home, you took rest after undergoing chemotherapy. Did you think the time had passed quickly or slowly?

56. P8: I suffered hard from chemotherapy so I thought the time had passed slowly. I felt helpless and did not know what to do. Other patients shared their experiences. They asked me to treat the disease as a serious flu and to take rest. They told me that I would suffer most during the 1st week and I would feel better as time went by. They reminded me to wear a mask when I

went out.

57. K: During the process, you felt the time had passed slowly as you suffered great pain. Did you think the time had passed swiftly in some situations? Alternatively, who did you get along with to make you delighted and feel that the time had passed quickly?
58. P8: I was glad when I got along with other patients. We had similar experiences. The experiences we had encountered were more or less the same. We gave encouragement and support to each other.
59. K: Would you offer help to other patients as you had past experience? Had you thought about it?
60. P8: Yes, I had. When I bumped into other patients who were just diagnosed with cancer in hospital, I shared my experience. I reminded them to take certain foods to facilitate the recovery and to take precautions. I assured them I could overcome the difficult time.
61. K: Did you share with these patients your Buddhist beliefs?
62. 20:32 – 24:43
63. P8: Yes, I did. I chanted for 'Gohonzon' in support of myself.
64. K: Did you pray for the patients or encourage them to believe in Buddhist teachings?
65. P8: Both. I prayed for them. If they suffered hard, I asked them to try chanting, which would assist them.
66. K: Was there any example showing their response when you encouraged them? Did they accept or object what you talked to them about? Please share this with us.
67. P8: The majority did not object to my suggestion. Some of them even accepted. They asked me how to chant.

68. K: They wanted to deepen their understanding about your religious belief as you used to be a cancer patient.

69. P8: Yes, they did. They wanted to know more about my experience. I tried my best to share it with them.

70. K: Did you think you were practising the Buddhist's teachings?

71. P8: I thought so. Having this disease reinforced my belief in 'Gohonzon' in my heart. 'Gohonzon' was the only one I placed trust in.

72. K: I will summarise what you have told us. You had the disease. You felt so depressed that you thought of committing suicide. Later, your younger sister and other SGI members gave encouragement to you to complete the mission of bringing up your 4 children. This enhanced your motivation for survival. Gradually, you chanted and changed your mind. In terms of your behaviour, you were depressed at the beginning. Later, you encouraged other patients in hospital to chant and you prayed for them. Was that the situation? Do you have any supplemental information?

73. P8: You were right. I prayed for everyone I met. I hoped I could bring fortune to them.

74. K: You recapped your memory. The time had passed quickly during the sickness period. However, when you underwent the painful treatment of chemotherapy, the time had passed rather slowly. You were not much affected by your change of body shape. Was I right?

75. P8: Yes, you were. The change of body shape did not affect me much. I had to change my diet and do more exercises to maintain a healthy body.

76. K: Could you please tell me in detail what the changed habits were?

77. 24:44 - 26:14

78. P8: I tried to avoid bad temper. I should take a peaceful mind and not pay

attention to minor things.

79. K: Could you talk about how you were in a bad temper? How did you behave before getting the disease?

80. P8: I had a bad temper towards my children and family members. I worried seriously that their bad behaviour would affect their future. After chanting, attending talks and accumulating personal experiences, I realised that children should experience mistakes and failures as long as there was no danger.

81. K: For example, you were very fierce and blamed the children seriously for misbehaviour or speaking improperly or they were impolite. Was it the case?

82. P8: Yes, it was.

83. K: Could you please give me some concrete examples?

84. P8: Those were the trivial things. For instance, they did not flush the toilet. They did not write neatly. They did not perform well in dictation and examination. I hoped they spent more time on revision and studied harder.

Participant went to toilet and stopped the tape recording.

85. 0:00 – 5:12

86. K: I intended to ask you about the Buddhist teachings and chanting that were mentioned by you. Did you join any activities of SGI? Thank you.

87. P8: I rarely joined the activities of SGI. I was more active in participation when I was in the females' team Girl Division. Since I had been married, either my mother or my younger sister sent me the notes or told me what they had heard from the Chairman after taking the lessons.

88. K: You did not go to SGI during these 20 years, did you?

89. P8: No, I did not. I relied on my mother and my younger sister for passing me the advice of the Chairman to remind myself.

90. K: Could you please tell me why you did not go to SGI?

91. P8: It was because my husband did not believe in Buddhist teachings. Instead, he worshipped gods.

92. K: Did your husband worship ancestors, Guanyin or any other gods at home?

93. P8: He worshipped ancestors at home.

94. K: Did he object to your participation in SGI activities or did he act in other ways?

95. P8: Yes, he objected to my participation in SGI activities. However, he was aware of my belief in Buddhist teachings in my heart as I used to join the females' team.

96. K: Your husband did not believe in Buddhist teachings. Did your four children follow your belief in Buddhist teachings or have other religious beliefs?

97. P8: Up till now, they do not believe in Buddhist teachings. They follow their father in worshipping gods.

98. K: You mainly relied on your mother and younger sister for passing the instructions of Buddhist's teachings to you, didn't you?

99. P8: Yes, I relied on my mother and younger sister for passing the instructions of the Chairman and the Buddhist teachings to me.

100. K: I would like to ask if you chanted yourself.

101. P8: I chanted more frequently in times of difficulties. In daily life, I did not chant too often.

102. K: You acquired the knowledge from your mother and younger sister. How did they pass the message to you?

103. P8: My mother talked to me. My younger sister bought some books or lent the books she had read and considered good to me.

104. K: By the time you were sick, did the SGI members pay visits to you or keep contact with you continuously?

105. P8: They paid me a visit twice. Once I recalled a member whom I knew from the females' team. She had suffered from breast cancer and had been recovered for 5 years. She gave enormous encouragement to me.

106. K: Did she talk about the instructions of the Chairman? Did she talk about anything that was particularly impressive to you?

107. P8: She had talked about the instructions of the Chairman. There was a book about the mission of yourself. I had to carry out the mission that I was obliged to do.

108. K: What did you think was your mission in the future?

109. P8: My future mission would be … to do the best so that I could be a model for the children to follow and they could achieve a good future.

110. K: I would like to ask if you had worries about the recurrence of your disease and if you had thought about your future.

111. P8: I had worries about the recurrence of my disease. I did not think about the future. I focused on doing the best for the present. I treasured everything and felt grateful for every matter.

112. K: I would like to ask if you had thought about your mission after your children had fully grown up, e.g. 10 years' time.

113. P8: The mission after my children had fully grown up was… to share my experience with others so that they were not scared of difficulties. They

were able to overcome difficulty that was similar to mine.

114. 5:13 – 7:32

115. K: As your children would be fully grown up in 10 years' time, you would not need to take care of your kids, so you would consider doing voluntary work, the same as those patients in hospital giving encouragement to you. You intended to give encouragement to other patients. Was that what you meant?

116. P8: Yes, it was. It was my intention to do voluntary work. I wanted to help others, i.e. breast cancer patients.

117. K: This was your future mission. At present, you are still busy. Did you have any plans about learning Buddhist teachings?

118. P8: In the aspect of learning Buddhist's teachings, I planned to read more books and chant.

119. K: Did you read the SGI newspaper, magazine or other information?

120. P8: Yes, I did. However, I did not read a lot.

121. K: You did not subscribe to it yourself. Did your younger sister give it to you?

122. P8: I did not subscribe to it myself. My mother and younger sister gave it to me. My mother applied for SGI membership for me when I was small.

123. K: When you were small, your mother brought you to join SGI. Then, you attended the females' team gathering by the time you were a teenager. By the age of 20, you got married and you no longer went to SGI. Was that the case?

124. P8: Yes, I scarcely went to SGI since my marriage.

125. K: You mainly heard of Buddhist teachings from your younger sister. I wanted to ask if you found any instructions of Buddhist teachings most impressive. Could you please talk about it?

126. P8: I recalled the instructions of the Chairman about the meaning of "spring will come after the winter seasons". Though the disease was very difficult and caused huge suffering to me, I was able to recover from it.

127. 7:33 – 10:51

128. K: I would like to ask about the relationship between you and other people. Did you have contact with other friends? Or you were rather introverted as a housewife? You only kept contact with family. Did you have plenty of friends or only a very few friends? Could you talk about it please?

129. P8: The majority of my friends were mainly parents of my kids' classmates. Some of them were close. I have told them about my personal experience. They gave mutual encouragement and support to each other.

130. K: It was mainly the parents of your youngest son's primary school. Some of them were your close friends. Could you please tell me how you spent your time in daily life?

131. P8: In daily life, I woke up in the morning and woke them up. I woke up at 6 am and woke them up at around 7 am. They arrived at school before 8 am. After they left, I went to buy food. In fact, it was preferable to do exercises before buying food. Then, I went home to do house chores after buying food. I cleaned the food. I cooked meals and boiled soup. I cooked lunch for my 2 elder daughters. Sometimes they stayed at home but sometimes they did not. After cooking the meals, they went to school in the afternoon occasionally. After that, I did the rest of the house chores. I did the laundry, folded the clothes, swept the floor, mopped the floor, washed the dishes. Later, I helped to do the simple paper work of my husband's office. It came to 3 pm. The kids returned home from school. I monitored them doing homework. Then, I asked the kids to do revision. Later, we had dinner. I

walked around with my husband after having dinner. I tidied up and cleared the rubbish bin. Finally, I went to bed.

132. K: It seemed that you worked the whole day for the family. You did not have your own entertainment. Was it the case?

133. P8: Yes, it was. The majority of time was spent on family. I did not do anything for myself. In fact, I should have spent more time on doing exercises, reading books or having entertainment such as listening to music.

134. K: You mentioned about your diet earlier. I wanted to ask if you had changed your diet these 3 years. Did you have a different diet between the sickness period and the recovery period?

135. K: Could you please talk about it?

136. 10:52 – 14:37

137. P8: Yes, I did. During the sickness period, I kept a simple diet. I only ate pork and Flowering Chinese cabbage. I ate less of other food. I took Chinese medicine for a period of time but I take less now. At present, I can eat a normal diet and there is nothing special.

138. K: Did you avoid any food in your diet?

139. P8: I always avoided seafood. I did not eat much shrimp and crab. I took any other types of food.

140. K: During the whole process, what did you feel? You thought that you mainly helped others instead of yourself. You thought that you contributed a lot to your family, didn't you?

141. P8: Yes, I did. I believed that family was very important. I put effort in to cleaning the house so that the children scarcely had sickness. I tried to buy some nutritious food to keep my kids healthy.

142. K: I would like to ask if you talked about Buddhist teachings and chants as your husband objected to your Buddhist belief.

143. P8: Yes, you were right. I did not chant when my husband was at home. I chanted in my heart.

144. K: So you returned to your mom's home once a week. You chanted out loud at that time. How long did it take?

145. P8: The longest time I chanted was around 2 hours. The short chanting took from half an hour to one hour.

146. K: What was your usual practice?

147. P8: I chanted for at least one hour.

148. K: The largest support for your religious belief came from your mother and younger sister, didn't it?

149. P8: Yes, it did. The largest support for my religious belief came from my mother and younger sister.

150. K: I made a conclusion first. Your husband objected to your Buddhist belief. Thus, you did not chant at home. You chanted in your heart. You only chanted when you visited your mom once a week. Your younger sister lent books, sent WhatsApp messages and information to you. What did you think your belief in the future would be? Would your religious belief sustain?

151. P8: I was confident that my religious belief could sustain.

152. K: Even though your husband objected to it?

153. P8: Yes, my belief could sustain despite my husband's objection.

154. K: Other people did not affect your faith in Buddhist teachings. Even your husband did not affect your confidence. You had confidence in chanting and belief in Gohonzon, didn't you?

155. P8: After experiencing this disease, I had a firm belief in Gohonzon.

156. K: Was it because you had not personally experienced the strength of daimoku before? This time, you experienced the whole process of sickness, chanting and recovery. Could you please elaborate?

157. P8: Yes, it was. I strongly felt the strength of daimoku through my personal experience in this sickness.

158. 14:38 – 16:55

159. K: Fine, thank you. Finally, I made a conclusion here. During today's interview, Ms. Chan thought that the Buddhist belief enabled her to overcome the breast cancer. In particular, at the beginning stage of the sickness period, several patients paid visits to her. There were two of them. The first one was her classmate in secondary school, who had been an SGI member since she was a teenager. She had recovered from breast cancer 5 years ago. Another one was Mrs. Lau from the Women's Division, who had experienced breast cancer for more than 10 years and recovered; she gave encouragement to her. She recalled a saying that "spring will come after the winter seasons". She felt that there would be a good result after going through a difficult time. Her view had turned to become more positive and optimistic. I heard from her that when she was a child, she felt inferior. She thought that she was not as capable as others. However, as she chanted, she did her best. From her point of view, she stressed how to be a good mother. For example, when she taught her children, she was bad-tempered and scolded them when they were not well-behaved. Nevertheless, after chanting, she could control her emotion and grasped the way to teach her children. Despite her husband's objection, she was confident she could sustain her confidence in future. She mainly relied on her younger sister and mother. She herself did not attend the activities of SGI. For instance, she

has not attended any monthly regular meetings during the past 20 years. However, she paid a visit to her mom's home every week and chanted during the visit. The longest chanting time took 2 hours and the usual practice took half an hour or one hour. The conclusion was that she would not give up her confidence in the future despite her husband's objection. This was the summary of the interview. Ms. Chan, I would like to ask if the above was right or if I misunderstood or if you have any supplemental information. Thank you.

160. P8: You talked very well. I do not have any supplemental information. Thank you.

161. K: Fine. Today's interview has come to an end. Thank you. Now it is 12:00 noon.

G. : Examples of sub- themes of Chemotherapy

Participant 1 interview 1 and 2 and Participant 2 interview 1 and 2 for assessment of reliability: Key word searching codes: chemotherapy

1. "full package" which included chemotherapy
2. Covered the expense of the chemotherapy
3. the chemotherapy became free of charge
4. each chemotherapy was charged at around two thousand
5. Insurance covered the expense of the chemotherapy
6. The chemotherapy was given six times
7. The chemotherapy followed by RT and hormonal therapy
8. The effects of chemotherapy were quite severe,
9. especially after the first injection of the chemotherapy…I had suffered severe hair loss
10. The chemotherapy side effects were very serious
11. More side effects after the chemotherapy
12. It was a difficult time in the chemotherapy stage.
13. I would have a chemotherapy injection the next day
14. Injection of all the target therapy and the chemotherapy medicine which would be mixed
15. Caused serious suffering during the chemotherapy treatment period
16. I believed that my Buddhist beliefs supportive merits made me comfort in going through the whole day of chemotherapy.
17. Moreover, I had the second dose of chemotherapy injection after three weeks.
18. Then, the next chemotherapy injection would be delayed

19. When I underwent my first chemotherapy injection, there were eight patients
20. Many patients suffered during the chemotherapy staging. Many patients' appearances changed
21. I ate a bowl of congee in the chemotherapy ward
22. I was admitted to the day chemotherapy admission ward which included lunch
23. Ate a bowl of congee during all the chemotherapy injection periods
24. Effect after finishing all the chemotherapy injections
25. When I had the chemotherapy, there was irritation and annoyance and it was sometimes painful
26. It was because the chemotherapy injection would destroy all the cells
27. She also needed to have chemotherapy injection.
28. She suffered seriously in the chemotherapy period
29. Was reluctant to continue the chemotherapy injection as she could not tolerate
30. Attended some lectures to learn some chemotherapy care
31. Some people did not want to purchase the chemotherapy injection.
32. It was expensive
33. No matter how expensive the chemotherapy was.
34. If the family members bear the cost of the chemotherapy
35. Some people might perceive the chemotherapy as being a very painful experience.
36. The chemotherapy was a big trauma
37. The destructive effect of chemotherapy was severe. I had experience of urinary tract infection that caused me a lot of pain after voiding urine.
38. Experience of bleeding during my chemotherapy period

39. My pile caused me a massive bleeding after bowel open which was during my chemotherapy period.
40. Cost a lot from the chemotherapy
41. Doctor explained the fee of the chemotherapy injection charged by the government
42. Charge was doubled if the chemotherapy was conducted in a private hospital
43. All the treatments such as chemotherapy, radiotherapy, etc. I myself took

H: Published Abstract in the Breast Cancer Summit 2017

Title: The Buddhist Coping Experience of Breast Cancer Survivors: A Phenomenological Approach

Investigator: Ms. Lai Oi Ling, Dr. Stuart McClean, Dr. Mary Mitchell

The University of West of England, Glenside Campus, Blackberry Hill, Bristol BS16 1DD, United Kingdom

Abstract

Purpose: This study aimed to explore the spiritual impact of the Buddhist beliefs as a lived experience on breast cancer survivorship in the Hong Kong culture.

Methods: A phenomenological research design guided the data collection. A purposive sample of 10 women who survived breast cancer, coming from the SGI, FGS, was interviewed two times. Twenty semi-structured, in-depth and face-to-face interviews were conducted in the community. All of the participants came from different Buddhist schools, practiced Buddhist meditation, and chanted the sutra daily. Their unique lifeworld stories reflected on the Hong Kong healthcare context. Two layers of data reduction included thematic analysis and van Manen's method. The researcher conceptualised themes under the lived space, lived body, lived time, and lived human relations. The hermeneutics approach elaborated the participants' lives including being, being-with-others, and being-in-the-world.

Result: These women expressed that the Buddhist mindfulness and chanting meditation have led them to be open and to accept all experiences in their way. The survivors perceived breast cancer as an opportunity to discover their own

Buddhahood no matter what difficulties they encountered. Two significant stresses came from the suffering during the treatment and fulfilling their role as a mother. Four Buddhist coping themes were (a) transforming their negative karma, (b) opening up own Buddhahood, (c) fulfilling the Bodhisattvas identity, and (d) hope and future. All of the participants had performed two patterns: "to actualize their essence of life" and "to study and practice their Buddhist faith." Body and mind changed from passive "being helped by others" to active "to empower and encourage other people."

Conclusion: Searching for the meaning of life is important to help breast cancer patients cope with the adversity of living with cancer. The author suggests that cancer survivors define their ultimate goal in life and explore the significance of their faith, which empowers them to achieve happiness in their own unique way.

(words: 316)

Biography

Ms. Lai Oi Ling started her Professional Doctorate in 2012 at the University of the West of England. She is a registered nurse in a Hospital Authority and a member of the Hong Kong Soka Gakkai International. She is actively participating in the Hong Kong Cancer Fund as a volunteer lecturer in patient education. I express my sincere gratitude to my supervisors Dr. Stuart McClean and Dr. Mary Mitchell for their expert guidance.