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Personality, counseling and the cancer patient

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PERSONALITY, COUNSELING AND THE CANCER PATIENT

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CHAPTER I

INTRODUCTION

Since the beginning of recorded history, cancer has existed in all strata of plant and animal life. It is a growth process in which the cells begin to multiply beyond the limits designed for normal cells, without organization. These cells are a part of the total body which is in a constant state of change-growing and dying, repairing injuries, reproducing, adapting to the environment or failing to adapt. These cancer cells, however, hinder the normal, healthy process of growth. Depending on the individual, the cancer can overtake any or all parts of the body and eventually lead to death.

Much study has been done on the different types of cancer cells and the broad spectrum of diseases that actually exist within this diagnosis. Various predisposing factors and external influences favoring their development are being examined. A majority of those studies are centered around the cellular, viral, immunological and environmental factors considered in the etiology of cancer. More recently, some research has also been done on the relationship of one's personality to the onset of any neoplasm or new growth.

More and more people are being affected by the growth of cancer cells within their bodies and, hence, are concerned with cures as well as prevention of this life-threatening disease. Cancer kills about 365,000 Americans every year. This incidence rises about two percent annually. (American Cancer Society, 1975) With an impact such as this on so many

people, researchers today are doing all that they can to assess the interrelationship of all of the aspects of one's being (physical, psychological, social and spiritual) to cancer.

The concept of holistic medicine is being introduced into professional literature as one considers this mind-body relationship. Taking care of one's body before disease sets in is being emphasized in the public health education that prevails today. New diets, exercise and different forms of relaxation and meditation are being advocated.

But for those who have already received the diagnosis of a malignant disease, treatment follows. What kind of treatment depends on the cancer, the doctor and the patient. To those people interested in coming to terms with their newly acquired diagnosis, preventative and restorative treatment beyond chemotherapy or radiation therapy is often sought out. The latest in rehabilitation programs and supportive services still do not reach a majority of those in need, however.

The researchers in this study are concerned about what factors are involved in determining who actually does seek out adjunctive counseling for help in dealing with their diagnosis. In particular, personality factors of those who have cancer are examined. The more known about what motivates a patient to seek counseling, the easier it will be to develop rehabilitation and supportive programs to meet the needs of cancer patients. Hence, sanction for a research project such as this lies in the fact that the question of motivation regarding adjunctive counseling has not been dealt with specifically in the past. *

* In this study the pronoun "he" will be used when the authors intend to imply "he/she".

CHAPTER II

REVIEW OF THE LITERATURE

A. INTRODUCTION

The question as to whether or not an individual's personality is related to the onset of cancer has been discussed for centuries. Due to the dominance of the medical model, the discussion had been tabled by the beginning of the twentieth century. Most of the research that exists today is done on the effectiveness of various therapies used to cure the cancer such as chemotherapy or radiation therapy. Hence, these studies have been geared to looking at the physical aspects of this disease rather than the emotional aspects of it. The discussion of the relationship of one's personality to the development of cancer has only been referred to in the literature again during the last twenty-five years. (LeShan, 1956) Studies are now being undertaken to determine the importance of the cancer patient's personality in the development of, maintenance of, and recovery from a neoplastic disease. Dr. Lawrence LeShan, a renowned researcher on this topic, viewed the etiology of cancer in the following way:

> "that an individual does not just 'get' the malignancy which starts on a cellular, immunological or endocrinological or psychological level. The entire organism eventuates toward cancer. His <u>total</u> biography, involving all its levels, moves in a direction leading to a total, organism-in-an-environment situation which is a neoplastic disease." (LeShan, 1969)

In this research project, the researchers are concerned with the total person, how he looks at himself, his disease, and those people

around him. To better understand these relationships, the following literature was chosen to be reviewed and discussed. To begin with, the research will be reviewed that has already been completed on the various personality characteristics of people who have cancer. The material that has been published concerning the way in which people cope with the diagnosis of cancer will also be reviewed. In this study, the researchers are concerned with this coping process and, as social workers, do want to understand the process an individual may go through during his adjustment to this diagnosis. In this review, then, what the literature says regarding the manner in which various people actually deal with this change in their life situation will be discussed.

The last section of this review will cover the types of support services, therapies and programs that have been developed, or are in the process of being developed, to assist people in their ability to deal with their illness. It is the researchers' desire to better understand how people can cope effectively with their illness and hence, what professionals can offer to them in terms of education, support or various types of counseling to make the diagnosis of a life-threatening illness, and the subsequent changes in their lives, meaningful. Hence, in this review, studies done on personalities of cancer patients will be summarized as well as the various ways in which people have coped with their illness. Finally, to be illuminated on will be how social workers and other professionals can meet their needs through various programs and services.

B. PSYCHOSOMATIC ASPECTS IN THE ETIOLOGY OF CANCER

Different people have written, in the past, on the correlation between personality factors or life history patterns and the appearance of

neoplastic disease. This concept had been advanced by doctors in the eighteenth and nineteenth centuries, but the idea had disappeared until 1952 when H. Tarlan and L. Smalheiser published a paper on the personality patterns of patients with malignant tumors of the breast and cervix. (LeShan and Worthington, 1956) Some of the predominant personality characteristics that are correlated with cancer will be discussed in this section.

1. PERSONAL LOSS

A common characteristic which was discussed by a number of researchers was that of having experienced the loss of a loved one or significant other in one's life. Dr. Lawrence LeShan discussed this occurrence as happening twice in one's life. He found in studies that he had done that very often in the first seven years of a child's life a physical event occured which damaged his ability to relate to others, such as the loss of a parent or the death of a sibling. This trauma caused a child to feel that emotional relationships brought pain and desertion. Loneliness was his doom. The child felt as though it was his own fault and hence, guilt and self-condemnation were his responses to this experience. LeShan found that a child with this kind of experience managed to adjust adequately to the environment from a surface point of view. However, the child still distrusted the relationships he had with others and felt that something was wrong with him. Very little energy was invested in relationships, and feelings of failure predominated. During adolescence or later the child had a chance to end the deep-rooted loneliness and poured himself into a relationship that appeared "safe". This relationship now gave the person meaning in life. The blow came when circumstances brought an end to this relationship--the second loss of a loved one. The person now had lost the meaning he once had in life

and viewed himself in isolation, as all alone and rejected. One way LeShan says that this person dealt with this dilemna was to "cease existing". LeShan stated that this person did not want to live, yet he feared death. For this person life afforded no hope and all that existed ahead was new pain. It is from six months to eight years after this second trauma that LeShan found the first symptoms of cancer appeared. This pattern appeared in 72% of the cancer patients and 10% of the controls LeShan studied over twelve years involving 450 adult cancer patients and 150 controls. He gave them all the Worthington Personal History Test; 150 were given a short series of interviews lasting from two to eight hours and forty-five were evaluated by means of intensive psycho-therapy for more than 5,000 hours. (LeShan, 1966)

LeShan stated in another article, however, that it was difficult to match individuals with a severe illness with those who were well. This was because it was difficult to determine the effect of the illness upon psychological data. The diagnosis of cancer also may have more attendant anxiety than any other diagnosis, and hence, this made it very hard to find a control group even of people with another diagnosis to compare with cancer patients. (LeShan, 1960) With this in mind, when discussing further research, then, the viewpoint of Dr. Bahnson will be taken, who stated: "It is a naive and mistaken assumption that one can talk about cause and effect at all. All we can do is organize observations over time, within different theoretical conceptual systems." (LeShan, 1969)

Another study, which discussed the relationship between cancer patients and their parents, was done by C. B. Thomas and K. R. Dusznski in 1974. A questionnaire was given to people who were suicidal, mentally ill, had a

malignant tumor, were hypertensive or had coronary heart disease. Closeness to parents, emotional demonstrativity and matriarchal dominance were studied. Thomas and Dusznski found a lack of closeness to parents in subjects who were suicidal, mentally ill or had a malignant tumor. Emotional demonstrativity was found to be low for suicidal subjects compared to others and matriarchal dominance was the highest for suicidal subjects and mentally ill subjects and lowest for those subjects with a malignant tumor. These researchers found no indication of excessive parental loss among the disorder groups. (Thomas & Dusznski, 1974)

Reznikoff was cited in another article to have done research with females with benign and malignant breast lesions. He found an apparent disturbance in feminine identification and a history of excessive responsibilities during childhood. (Surawicz, Brightwell, Weitzel & Othmer, 1976)

In research on patients with leukemias and lymphomas by Dr. Greene, he found that these diseases occurred in settings in which patients are dealing with loss and separation, also. (Bahnson, 1969) In the same regard, Goldfarb, et. al., did research with cancer patients in which he found those people were unable to accept the loss of a significant other or object. (Brown, 1974)

2. EXPRESSION OF ANGER

The next personality characteristic which was found to have been written about extensively in the review of this literature was that of an inability to externalize one's anger. To be able to externalize one's anger meant that one was able to express hostility verbally or physically in a constructive, satisfying way rather than to have kept it all inside oneself without expressing it outwardly to oneself and/or others. The effect

that internalizing one's anger could have on one's health has been discussed by a variety of people. Medical professionals have been aware of its impact on one's health for years. A letter written in 1402 by a physician, Maestro Lorenzo Sassoli, to a patient, was quoted as saying:

> " . . . let me speak to you regarding the things of which you must most beware. To get angry and shout at times pleases me, for this will keep up your natural heat; but what displeases me is your being grieved and taking all matters to heart. For it is this, as the whole of physic teaches, which destroys our body more than any other cause." (LeShan, 1959)

LeShan and Worthington in a study done with 250 patients with malignant neoplasms and 150 people without cancer found that the cancer patients were unable to express their hostile feelings and often put on a front of goodness and kindness. These 250 patients found it difficult to express feelings of anger in defense of themselves. (LeShan and Worthington, 1956)

Kissen in 1963 did a study in which he found cancer to be associated with "bottled up" emotions and with a greater tendency to contain their feelings than those in a control group. He also found that individuals with cancer reported less acting out behavior as children. (Watson & Schuld, 1977)

Another study was done which looked at those people with rapidly growing cancer versus those with slowly advancing cancer. Ellis, the author of this study in 1956, found that the former tended to show more defensiveness and lower acting out levels on the Minnesota Multi-phasic Personality Inventory than the latter. (Watson & Schuld, 1977)

G. Nemeth and A. Mezei studied fifty cancer patients by using the Rorschach test. They then compared responses of those with benign tumors to those with malignant tumors. More interest in life was found in the

benign tumor group as well as a greater attempt to assert themselves. The benign tumor group had more difficulty than the malignant group in accepting their new dependency role. This defense against dependency was the cause of a continuous struggle to maintain independence. Nemeth and Mezei stated at the end of the study that it was a person's readiness for fight, the drive force of hostility, creativeness and the intense threat of the life and death issue at hand that played an important role in the occurrence of malignancy. The malignant group, on the other hand, scored high on passive hostility as compared to the benign group's hostility score which was on the active side. (Nemeth & Mezei, 1964)

In 1968 K. M. Stravraky, et. al., did a study in which they used the MMPI and the Differential Diagnostic Technique (a projective technique of personality investigation aimed at revealing basic personality characteristics which might otherwise be masked by the subject's psychological defenses.) This study looked at the duration of survival from the first date of admission for treatment to the London Clinic. The results showed that the patients with the most favorable outcome are more frequently hostile than those patients with cancer who survive an average length of time. The study reported that a combination of active hostility and above average I.Q. were particularly outstanding in the favorable outcome group. (Stravraky, et. al., 1968)

A similar study was done by Blumberg in 1954 on the survival time of fifty cancer patients by using the MMPI. This study also reported that a short survival time was correlated with behavior which was passive, yet anxious and less able to reduce tension by external discharge. Those patients with cancer who lived longer were found to be more expansive and

able to decrease anxiety by outward action. (Goldfarb, Driesen, and Cole, 1967)

C. B. Bahnson and M. B. Bahnson in 1969 looked at ego defenses in the personalities of cancer patients. Through the use of the Bahnson Adjective Check List and the Bahnson Projective Check List as well as an interview, they found that the cancer group subjects scored below the normal control group subjects in their projection of anxiety, depression, hostility, guilt and dominance. Bahnson and Bahnson stated that the cancer group subjects had a lower projection rate because they were unable to respond to the environment, being unable to describe it as negative or threatening to their emotions as normal subjects did. (Bahnson and Bahnson, 1969)

Another test was done on the psychological attributes of women who developed breast cancer in which this same characteristic of a suppression of anger was found. Greer and Morris in 1975 completed this study on 160 women prior to their diagnosis of cancer. There were many characteristics in which there were no differences between the cancer patients and the noncancer patients; for example in social adjustment to marital relationships, in interpersonal relationships, in work and leisure, in percentage of people with psychiatric disorders, and in I.Q. level. However, Greer and Morris found a highly significant difference between the control group and the cancer group in regard to suppression versus expression of anger. Those cancer patients over forty years old suppressed feelings the most. (Greer and Morris, 1975)

This particular characteristic of passivity and/or repressed anger has been noted by innumerable studies and hence, was one of concern when

looking at the personality of an individual as related to the etiology of cancer. If it is true that it is not "healthy" to keep one's anger inside, social workers need to be aware of that quality both within themselves and others with whom they are working in order that they may model a more "healthy" response to the environment.

3. DEPRESSION, DESPAIR AND LACK OF PURPOSE IN LIFE

A difficult, but interesting personality characteristic to study has been that of depression. A number of researchers have studied this characteristic as it related to cancer. There are many kinds of depression, but the syndrome descriptive of that which many cancer patients experience was what would be termed reactive depression. This was described by Joseph Mendels as a "depressive condition that arises in association with stressful experiences in a predisposed individual." (Mendels, 1970)

One of the ways an individual might have developed a predisposition for reactive depression was by having a "depressed personality". Laughlin in 1956 listed some traits that this individual might have. For example, he may have been overserious, dependable, studious, conscientious, gloomy and subdued. He may also have an increased vulnerability to rejection, disappointment, and frustration when let down. This individual might also be unable to externalize his anger, and therefore, be compliant, conciliatory, overpolite and subservient. Features of the obsessive-compulsive personality, including meticulousness, rigidity, perfectionism and concern with detail were also traits this person might have possessed. Laughlin also stated that another contributing factor in the development of a predisposition for reactive depression could have been a childhood loss or

stress at a crucial period of development and then, a recurrence as an adult of a similar loss or stress. Finally, a poor self concept could have lead to this predisposition for reactive depression. (Mendel, 1970)

Since a "cancer personality" syndrome has not been proven to exist, one could only conjecture as to what impact depression did have on the etiology of this disease. Just what role did depression play in the triggering of cancer? A. H. Schmale and H. Iker discussed depression in a study which they completed on hopelessness as a personality characteristic of females with cancer of the cervix. They discussed the tendency for some individuals to feel like "giving up". In other words, these individuals felt that they were unable to cope with an actual or fantasied loss of gratification. (Schmale & Iker, 1971)

LeShan also had written on what he called "Weltanschauung" or despair as a personality characteristic of people with malignant diseases. He stated that these individuals experienced a bleak hopelessness about ever achieving any purpose in life. They tended to feel all alone and are unable to relate to others. These people no longer believed that outside "objects" could bring them satisfaction or that any action that they took on their part could ever ease their feelings of aloneness. (LeShan, 1961)

Frankel has done research on this concept of emptiness of purpose in life. Crumbaugh and Maholick developed the Purpose in Life Test based on Frankel's research. Frankel defined this emptiness of purpose in life as a "noogenic neurosis". The chief dynamic of this neurosis, he said, was "existential frustration" created by a vacuum of perceived meaning in personal existence and manifested by the symptom of boredom. (Crumbaugh & Maholick, 1964) In other words, an individual with depressive tendencies

often lacked purpose in life, was bored and questioned his quality of life.

One's outlook on life does influence one's health as one's mental health interrelates with one's physical health. In the twenty-seventh World Health Assembly Technical Division in Geneva in May of 1974, psychosocial factors as they relate to health were discussed. Quality of life was defined as a combination of one's physical, mental and social well-being, in whatever combination required to make one happy and satisfied with life. Included in this area of life satisfaction were: health, marriage, family, job, housing, financial situation, educational opportunities, self-esteem, creativity, competence, belongingness and trust in others. (Levi and Anderson, 1975) All of these areas have been topics of concern in the personality characteristics of cancer patients.

Interestingly, Schmale and Iker did a study in which they reported that many cancer patients noted feelings of hopelessness and depression within a period of six months prior to the onset of cancer. In correlation with these depressive and hopeless feelings, these authors wrote that there were other personality characteristics which could be associated with a high predisposition for experiencing hopelessness. Traits such as a low self-esteem, a desire to be perfect, and a preoccupation with pleasing others with frequent feelings of guilt and shame experienced when their efforts did not meet their expectations, were found to be in existence in many of these cases. When testing, Schmale and Iker found that the cancer group subjects did have higher depression scores and lower ego strength scores on the MMPI. This was a predictive study as these people were tested and rated prior to the time that their diagnoses were made. Schmale

and Iker hypothesized that a high degree of hopelessness may lead to a loss of ego control which makes one vulnerable to physical deterioration, for women who are already biologically predisposed to cancer of the cervix. They conjectured that a cellular dysplasia is the initiator and a psychological experience of hopelessness as a promoter agent in the development of cancer. (Schmale and Iker, 1971)

LeShan, in his study of the emotional life history pattern associated with cancer, stated that this depression eventually becomes despair. These people, who had suffered the loss of a loved one, became utterly despaired of even being themselves. They became frustrated, however, as they were afraid to express this feeling for fear of rejection. They became very defensive, covering up any real needs that they might have, especially for love. The despairing person differed from the depressed person, though, LeShan wrote, in that this person kept himself busy. A depressed person would gradually do less and less. He stated that many cancer patients chose to keep on living in the way that they had been; very few chose to change their way of life or activity. According to LeShan, those people who denied their real needs were often those who saw themselves as people who complied to the wishes and demands of others and the social system as they saw it. They were the "good, decent, kind, thoughtful" people. Others' wishes and needs were perceived as right and theirs as wrong. Giving more to others and not receiving as much in return seemed justified to them. (LeShan, 1966) Goldfarb, et. al. have also done studies on the personalities of cancer patients and, like the aforementioned reports, found many of these people unable to accept the loss of a significant "other" and to have preneoplastic feelings of hopelessness, helplessness

and despair. (Brown, Varsamis, Toews & Shane, 1974)

4. LOCUS OF CONTROL

How much control a person has over his current life situation varies from person to person, according to the belief system of each individual. Reid, et. al. defined the locus of control as the extent to which a person saw his outcomes (events he experienced and reinforcements he received) as being contingent upon his own efforts and abilities, specifically, internal; or as being determined by chance, fate and powerful others, specifically external. (Reid, et. al, 1977) As stated earlier in a study by LeShan in 1961, many people with cancer do not believe that any action they have taken will remedy their current life situation; he referred to loneliness. (LeShan, 1961)

To feel as though one has lost control of one's life situation, or to feel as though one was a "victim" of the cancer in one's body, was a common initial response to this diagnosis. People responded differently, though, from that point on, depending upon how they viewed their ability to control any other situation in life. One study done by Wolk in 1976, using Rotter's Internal-External Control Scale found that internality was associated with adjustment, satisfaction, positive self concept and maintenance of activity. (Reid, et. al., 1977) To feel as though one could still make some choices in one's life after the diagnosis of cancer gave that person a feeling of control. Doctors were urged to encourage the cancer patient to participate in the treatment of his disease. In an article entitled, "What Contributes to Hope in the Cancer Patient?" by J. A. Buehler in August of 1975, the following quote by Koenig was found

regarding this matter:

> "Cooperative alliance was generally sustained as the patient continued to believe he was actively participating in his treatment and that he still retained some degree of control over his life." (Buehler, 1975)

Feelings of helplessness, hopelessness and lack of control over what is happening in one's life as segments of one's personality have been examined, thus far, as they relate not only to the onset of cancer, but also to the maintenance of it, once diagnosed. People with cancer have not always been aware of the options available to them in their response to cancer and hence, might have looked at the situation in this way; that is, expressing those feelings of helplessness, hopelessness and futility and not believing that they have any say in what happens in the future. It is this outlook or attitude which patients may have that doctors, as well as other helping professionals must understand in order to help their patients take more responsibility for their lives and maintain an attitude of hope within themselves.

5. SELF CONCEPT

A negative attitude toward a life with cancer is often a reflection of one's self concept. Schwab, Clemmons and Marder, in 1966, defined self concept as the product of personality formation, the sum of one's attitudes toward oneself which was reflected in one's behavior. (Schwab, Clemmons and Marder, 1966) The studies that have been done by researchers on self concept as it relates to cancer have found that a low self concept does exist in many patients. Schmale and Iker noted this, as well as LeShan. When testing 250 patients with malignant neoplasms and 150 people in a control group, LeShan noted a marked amount of self-dislike and an in-

ability to believe that they are worthy individuals. LeShan reported that 79% of the 250 cancer patients as compared with 34% of the 150 control group subjects indicated a poor self concept. LeShan used the Worthington Personal History as his testing tool. (LeShan and Worthington, 1956)

Schwab, Clemmons and Marder did a study in 1966 in which they interviewed 124 general medical patients in regard to sex, age, race, education, marital status, religious preference and annual income. They found that 15% had very low self concepts. Those with lower self concepts did feel that their illness had affected their lives adversely, on an overall basis. Also, they saw their prognosis as poor and exhibited greater anxiety in their lives. Furthermore, it was important for the doctor to know the patient's self concept, as it was a determining factor in recovery and in how the patient viewed his illness. In the doctor-patient relationship, anxiety may have interfered with the helpful, meaningful relationship which was necessary to promoting good health. (Schwab, Clemmons and Marder, 1966)

The manner in which one looks at oneself, be it as a valuable person or as a person without worth, affects one's outlook on life, one's meaning and purpose in life and one's ability to relate to others. Researchers continue to examine how this attitude toward oneself affects one's health.

6. SEXUAL ADJUSTMENT

One group of people who have been accessible for studies on precancer personalities has been women who have come in to the doctor's office for Pap smears and physical exams. Those women who may be hospitalized for biopsies are able to contribute data on themselves before

any changes in their personalities may occur, due to the diagnosis of cancer. In reviewing the literature on these studies, it was found that Booth in 1969 determined that cancer of the cervix occurred in sexually active, but sexually frustrated women. (Crisp, 1970) Women who develop breast cancer were also found to have a less satisfactory sexual adjustment than those who did not have cancer. Age was also a factor in this study, in that the women who developed cancer were older than those who did not. (Greer and Morris, 1975)

7. STRESS

Another aspect one must consider when looking at the personality characteristics under study is the amount of emotional stress experienced by individuals. What role does this existential stress play in the development of illness? Many researchers and clinicians do believe that a majority of the human illnesses that are developed are stress-related. That is why it is important to recognize what the nineteenth century physician, William Osler, said so well: "It is much more important to know what sort of patient has a disease than what sort of disease a patient has." (Rosenbaum and Rosebaum, 1978, p. 13)

Social pressures create the stressful need to "perform" for many individuals. Nations struggle against nations for power and control. Individuals struggle against individuals for status and prestige, especially in job situations. Minorities battle daily with the discrimination existing in our society. Due to these and many other such examples, each individual will either make some "healthy" adaptation to daily stress or find stress damaging to his body in the form of illness. Seyle in 1977

defined stress as:

> "the nonspecific response of the body to any demand made upon it. All agents to which we are exposed produce a nonspecific increase in the need to perform adaptive functions and thereby to reestablish normalcy. It is immaterial whether the agent or situation we face is pleasant or unpleasant; all that counts is the intensity of the demand for readjustment or adaptation." (Seyle, 1977)

Hurst, Jenkins and Rose (1974) said that the amount of adjustment required defines the stressfulness of the event. In this section we will look at research on stress as it relates to the onset of disease--more specifically, cancer.

Several authors have related stress to the onset of disease. The first and widely renowned such author, Hans Seyle, has researched the area of stress, having written thirty-three books and 1,600 articles. Seyle (1974) said stress is the rate at which we live at any one moment. "Complete freedom from stress is death", he said. As Seyle described it (1974), a vital part of the defense against stress is the excitation of the hypothalamus (the nerve center at the base of the brain). The hypothalamus releases a chemical messenger (CRF) which causes the pituitary to increase secretion of ACTH or adrenocorticotrophic hormone. ACTH stimulates the adrenal cortex to produce hormones called corticoids. A corticoid called cortisone causes thymus atrophy and also influences glucose metabolism. Various derangements in the secretion of these hormones can lead to maladies which Seyle (1974) described as "diseases of adaptation", not due to any particular pathogen.

Along with Seyle's investigations into stress, Dr. Thomas Holmes and Dr. Richard Rahe (1967) looked carefully at the relationship between social readjustment, stress and susceptability to disease. They found

that life events clustered and increased in intensity prior to the onset of disease. With their research they developed the Social Readjustment Rating Scale (SRE) which assigned numerical values to life events, both positive and negative. When adding the values assigned to each life event experienced in the last year, Holmes and Rahe could predict the chances of an individual developing an illness. Holmes and Masuda (1973) are quoted as having--

> "postulated that these life events enhance the probability of disease onset by lowering body resistance. This lowered resistance, they theorize, is due to adaptive efforts by the individual that are dysfunctional in kind and duration." (Pelletier, 1977)

Along with interest in disease onset and its relation to stress, interest has peaked in stress and its relation to the onset of cancer, specifically. In an animal study, Kavetsky, Turkevich and Balitsky (1966) found that the origin and growth of mammary tumors in mice are correlated with their type of nervous system. In the study, the unbalanced nervous system lead to more malignancy in mice. In examining research with human beings, Southam discussed how emotions might affect the onset or process of metastasis of cancer and Southam does not reject the idea of stress influencing the growth of cancer. (Southam, 1969)

Another recent study looked at the critical incidents in one's life as defined by the differences in frequency, intensity and duration of reported emotional and stress states of hospitalized patients. The experimental group included forty-four male cancer patients between twenty-six and sixty years old. The control group consisted of forty-four male patients with other diagnoses, between twenty-six and sixty years of age. Using an interviewing guide, the researchers explored the types of emotional states their subjects experienced throughout their life span and

their perceived psychological reactions to their emotion provoking conditions, be they in their childhood, family life, social and sexual life, etc. For the cancer group, they found 107 critical incidents which were high in emotional implications. In the non-cancer group the critical incidents only numbered forty in the same caliber. Hence, this research supported the notion that stress might be a variable in the onset of cancer. (Smith and Sebastian, 1976) Environmental factors (stress and emotional distress) might also be an aspect in the pathogenesis of cancer. (Solomon and Amkraut, 1972)

In this section, the importance of stress as it relates to illness has been examined. Recently, much has been written about stress as a trigger in the onset of cancer. At this point, the scales must be refined and the research on human beings must be controlled in order to stimulate thoughtful and meaningful research in the area of stress and disease.

C. COPING

The manner in which an individual responds to disease depends on how he views the total pathological process, what it means to him and how much he will then allow this meaning to influence his behavior and interaction with others. (Lipowski, 1969) A person who first receives the news of his diagnosis of cancer is traumatized, perhaps to the point of not hearing everything the doctor has told him. From this day on he begins to assimilate this devastating news into his life to the best of his ability. (Shands, 1966) In order to cope with the changes in his life because of this diagnosis, an individual may begin to utilize previously established "familiar" defense mechanisms to a greater extent. These defense mechan-

isms can be functional or dysfunctional, but nonetheless, they are essential in dealing with the life-threatening disease.

Schnaper, in discussing the psychosocial aspects of management of the patient with cancer, stated that denial is the most effective defense mechanism. The first stage in coping with this diagnosis is to negate the truth, not really believing that one has cancer. Schnaper stated, however, that denial connoted hope and as such, was as important to the cancer patient as were narcotics which were needed for pain. (Schnaper, 1977)

The information presented to an individual regarding his traumatic diagnosis takes time to assimilate. Shands, in his article on this subject, discussed how much easier it was for an individual to adapt to this distressing news if he was in a favorable social situation. The news, itself, was frightening as one reflected on the fact that one harbored his own destruction. (Shands, 1966) Therefore, support from one's environment is needed.

In a study done by A. Peck in 1972, on the emotional reactions to having cancer, he delineated the various defense mechanisms that people use who have this diagnosis. He studied fifty out-patients who were coming in for treatment for cancer at Mt. Sinai Hospital Radiotherapy Service. He stated that some of those who used denial used it as a defense against death from the cancer, not against the cancer itself. (Peck, 1972)

Many patients do go through a period of depression in the process of adjusting to the diagnosis of cancer. This depression is not proportional to the severity of the illness, however. C. G. Kardinal and H. T. Cupper,

in their study on the reactions of patients with advanced cancer to their diagnosis and treatment, stated that this depression was a function of one's previous life roles as well as one's previous psychological state. They did find that depression was a dominant early reaction experienced by many people. (Kardinal and Cupper, 1977)

Social withdrawal is one behavioral manifestation of a depressed person. This withdrawal or regression has been hypothesized to occur when one resents those who are helping him which, in turn, leads to feelings of guilt. This regression can lead to the point where a patient rejects any more help, refuses medication, and therapies and, therefore, dies. (Schnaper, 1977)

Other behavioral manifestations of depression noted in a study by J. Driyadharsini included motor retardation, a downcast facial expression, sleeplessness, absence of initiation of conversation and slow, dragging, monotonous speech. In looking at what factors may affect a patient's depression, Driyadharsini found that there was no association between age or time and the behavioral manifestation of depression. He did find an association between the educational level of the cancer patients and depression. He stated that depression decreased in relation to an increase in educational level. (Driyadharsini, 1973)

Depression may also be caused by self-reflection. The person may blame himself for the contracting of the disease and, consequently, put himself under severe stress because of this. R. C. Mastrovito discussed this as well as the fact that one who has cancer is not easily accepted socially because of the stigma and myths associated with this disease. He stated that even cancer patients viewed themselves as dirty, repulsive

and unworthy of help, usually having a low self-esteem in relationship to their disease. Therefore, the way in which a person saw himself within his current life situation may influence his prior self concept, depending on his conceptions of the disease. (Mastrovito, 1972)

In order to help others in their coping process with cancer, E. A. Lord wrote about her crisis with cancer. She was a nurse and mother of four children. She told of her use of intellectualization as a defense mechanism to prevent herself from falling apart and showing her real emotions. Once she was able to break through this defense mechanism six months later, she was better able to deal with her situation. (Lord, 1974)

Some cancer patients tend to identify with their doctor once having received the news of their diagnosis. By so doing, they can take on the 'powers' they believe a doctor has in order to cure the disease and they also feel as if they are taking an active role in the treatment of their cancer. Those who are accustomed to taking an active role in their illnesses use this defense mechanism in order to cope with this life-threatening disease. Their attempt to identify with the doctor's active fight against the cancer alleviates much of their anxiety. Along with this identification, these people have often attributed special powers to the doctor, expecting great miracles from him. (Peck, 1972)

To deal with this life-threatening disease, patients employ a variety of defenses, as explained above. Each individual tries to go back to that pattern of adaptation or technique by which he was previously able to overcome feelings of helplessness. In other words, it is important to many people who have this disease to regain or maintain some degree of control over their lives. As professionals, it is necessary to be available to

assist these people in their attempts to cope with cancer in ways that are functional and will enhance their ability to adapt to this life-threatening disease.

D. REHABILITATION AND TREATMENT PROGRAMS

Once a life-threatening disease has been diagnosed and the coping processes begun, cancer patients might take advantage of some of the treatment programs available to them in their community. In the last few years, interest has evolved in helping the cancer patient live and deal with his disease. In this section the idea of holistic health will be examined and the concommitant philosophies, types of treatment, and goals of treatment interventions.

The concept of holistic health has recently been examined and written up in the literature. Pelletier described a holistic approach to stress disorders in the following quote:

> "Holistic medicine recognizes the inextricable interaction between the person and his psychosocial environment. Mind and body function as an integrated unit and health exists when they are in harmony, while illness results when stress and conflict disrupt this process." (Pelletier, 1977, p. 11)

Pioneers in this domain of mind-body communication were Carl O. Simonton and Stephanie-Matthews Simonton. With the combination of visualization for physiological self-regulation and traditional radiology, they obtained unusual results. This team, consisting of a radiologist and psychologist Dr. Carl and Mrs. Stephanie-Mattews Simonton respectively, taught their patients to imagine their disease in their minds and through this visualization, imagine their disease being overcome by the immune mechanisms in their bodies. They suggested that patients should be treated as a whole,

not just in terms of a specific disease. In their studies, they found that the more positive the patient's attitude, the more positive the chance for recovery. (Simonton and Simonton, 1975) Along with the Simontons, Booth advocated for a holistic approach which offers hope to the individual. (Taylor, 1974)

According to Vettese, the optimal treatment should be total rehabilitation. Commencing with the diagnosis, planning for physical, psychosocial and financial needs is important in treating the cancer patient. (Vettese, 1976) Bahnson promoted a team approach, based on systems theory. (Bahnson, 1975) Sohl suggested group-self help services, peer group support systems and reference groups. (Sohl, 1975) Asker promoted counseling, therapy and family therapy. (Asker, 1975) LeShan stressed the importance of psychotherapy for the individual when he's dealing with a life-threatening disease. (LeShan, 1961) One must also be aware of the fact, however, that in a review of the literature, Miller found little information regarding effective approaches for aiding cancer patients to deal with the emotional and psychological reactions to the stress of learning that they have cancer. Miller stated that what existed in the literature were:

1) descriptions of personality characteristics of cancer patients,

2) their emotional reasons for not accepting the fact that they have cancer,

3) the psychodynamics of the defense mechanisms they employ and,

4) a few general suggestions for rehabilitation. (Miller, 1976)

The specific goals for the treatment of cancer patients vary from case to case because human beings are unique. Psychodynamically, Booth

conceptualized cancer as a somatization of the depressive process in which the neoplasm represented a substitute for a lost external object. Therefore, he stressed the need to help an individual to establish a new object relationship which offered hope. (Taylor, 1975) Vettese indicated the primary goal was to enhance the individual's quality of life. Also, the goal should be to help the cancer patient to become self-determining in the face of his future decision making. (Vettese, 1976) Francis discussed the importance of helping the patients feel better about themselves. (Francis, 1969) Both Francis and LeShan recommend accentuating the person's strengths and LeShan suggested that the therapist must help the patient to examine those things that have blocked these strengths. (LeShan, 1977)

In dealing with a weak will to live, one must help the individual learn how to live, not how to die. Also important in counseling is to help the individual tackle the deep problem of how to make the most of one's being. Helping the patient to develop thoughtful, deeply meaningful goals for the future will create an ideal for the person to work towards. Arousal of faith in the self and an ultimate concern for the self is necessary. The therapist, here, must express absolute caring and acceptance, developing a real 'encounter' between the patient and therapist. Paul Feden in 1932 was quoted as saying: "All that is living must be loving so as not to die." (LeShan, 1964) In other words, it is having love in one's life that gives it meaning, stimulating one to keep on living.

An important intervention with cancer patients is to develop a relationship based on trust. (Crary and Crary, 1974) Along with this bond, open communication is necessary and with it, discussions of the probabilities or likelihoods of the individual's disease recurring. Also, the therapist can help in maintaining the hope of not being abandoned, the hope of

the pain being adequately treated, the hope of the family's not unduly suffering and the hope that death will be as easy as possible. The therapist must focus on keeping the future open and focus on providing what the patient can enjoy. Finding alternative activities which patients can perform and alternative ways to perform gratifying activities are also goals a therapist can help a patient to work on. Healthy behavior should be rewarded and symptoms which can be treated should be the focus of treatment. Also, the therapist can help the patient to be aware of self-fulfilling prophecies, in other words, the concept that his thoughts will affect his future behavior.

Miller added the following principles of management of the patient with neoplastic disease. First, the patient should be allowed to know the truth and should know that his attitude could influence his prognosis. Psychotrophic drugs should not be allowed to interfere with the patient's mental functioning and his ability to maintain contact with reality. It may be important not to blame the patient for his delay in seeking medical treatment. Selling the idea to cancer patients that 'inoperable cancer' may even regress if the patient finds a solution to his pathogenic situation may provide hope for them. Finally, attempts should be made to find solutions to clarify his pathogenic situation. (Miller, 1977)

As previously mentioned, the Simontons and Pelletier believed in the use of meditation, visualization and relaxation to promote healthy individuals. They (Simontons) taught people these techniques which were practiced daily, and patients were given a relaxation tape and a book to read, entitled, The Will To Live, by Dr. Arnold Hutschnecker. With this material, the Simontons explained their concept of personal responsibility.

> "In order to really grasp the concept that they can mentally influence their body's immune mechanism, they must eventually realize that their mind and emotions and body act as a unit and can't be separated. There is a mental and psychological participation as well as a physical one, in the development of their disease." (Simonton and Simonton, 1975, p. 37)

As an individual learns about his diagnosis of neoplastic disease, he may decide to attain some kind of adjunctive treatment. In examining the concepts of holistic health, professionals are promoting positive, creative ideas about the mind-body relationship; that is, how one's psychological make-up affects one's physical make-up. Treatment may consist of anything from traditional psychotherapy to existential or behaviorally focused therapies based on relaxation. It is a matter of educating the public as to what is available to help them to deal with their life-threatening illnesses.

E. SUMMARY

From the review of the literature in the areas covered in this chapter, it is apparent that the subject of the interrelationship between one's personality and the onset of neoplastic disease is a current topic of study. In this study, the researchers are continuing to look at that interrelationship and how it affects one's adjustment to the diagnosis of cancer. Previous studies on coping mechanisms and treatments that are being offered to help people to cope are also aspects of this research project which are being examined. No one fits into a perfect "niche", but hopefully, through the review of some of the literature and this study, the reader can better understand what it is that individuals experience - once diagnosed with a life-threatening illness, and what effective intervention it is that professionals can offer.

CHAPTER III

METHODOLOGY

A. PURPOSE

This study was undertaken to determine whether personality characteristics can be utilized to distinguish those cancer patients who choose to participate in cancer counseling. Another part of this study looked at what other factors may be involved in the refusal of some people to participate in adjunctive counseling while others accept it. Research questions to be considered included the following: 1) Does the self-concept of a cancer patient affect whether or not he will choose counseling? 2) Are the cancer patients who choose counseling more internally controlled? 3) Are cancer patients who feel that they have purpose in their lives more likely to utilize adjunctive counseling? 4) Does stress prevail in the life of people with neoplastic disease prior to the onset of their diagnosis? 5) Is there an age difference between those who choose to participate in the counseling?

These research questions will be addressed in this study as the personality characteristics of a group of twenty-nine cancer patients are examined. The data compiled from this study will be used to discriminate between the ability of those who have sought counseling to cope with their diagnosis of cancer versus those who have not sought counseling and their ability to cope with their diagnosis of cancer.

B. DESIGN

Originally, this research project began with an interest in evaluating the Cancer Counseling Center Program for cancer patients run by Kaiser Permanente. The question was posed as to whether programs stressing the patient's responsibility in his own disease would affect his outlook on his life and whether this, in fact, would affect the course of his disease. Upon negotiating with the oncologist sponsoring the Cancer Counseling Center, resistance was found toward the initial study ideas. With new ideas and research questions from him, the study was modified. It was then approved by the oncologist, but did not get the approval of the Human Subjects Review Board from this hospital organization. Consequently, the research ideas were explored elsewhere.

The latest research proposal was then pursued with a private oncologist who was interested. This physician approved of the research proposal and negotiated in regard to the design and the feasibility of utilizing his patients for this study. This oncologist sees cancer patients, both males and females, all income ranges and all ages, living close by and far away. Men and women over twenty-one years of age were chosen to be interviewed and tested. These were persons who had any diagnosis of neoplastic disease and who lived within commuting distance of the counseling program. Each subject was to be seen at least six to eight weeks after his most recent cancer diagnosis, if at all possible, for the interview and testing. Each subject would then be telephoned six weeks following the interview to determine if he or she had attended the cancer counseling center or had sought counseling elsewhere.

C. INSTRUMENTS

The instruments utilized were an interview plus three tests. The three tests included the Tennessee Self Concept Scale, the Rotter's Internal/External Control Scale (I-E Scale), and the Purpose in Life test. These tests were used to look at the personalities of cancer patients who see this private oncologist. A copy of each instrument is found in Appendix C, D, E.

The interview consisted primarily of demographic data including: 1) birthdate, 2) race, 3) marital status, 4) income level, and 5) highest educational level achieved. Along with this information, subjects were asked: 1) whether they had any history of cancer in their families, 2) what their diagnosis was, 3) when the diagnosis was made, 4) what type of treatment they were receiving now, if any, and 5) whether they experienced any particular stress prior to their cancer diagnosis. A copy of the questionnaire is found in Appendix B.

As previously mentioned, prior studies have looked at the self-concept of cancer patients. In this particular research study the interest is in whether cancer patients do, in fact, have low self concepts. Do low self concepts in individuals lead to the possibility of a diagnosis of cancer? Since the Tennessee Self Concept Scale does measure self-concept, is short in length and easy to complete, this test was chosen as one which would be appropriate for this study.

Fitts authored the test, which he began working on in 1955. The scale that was developed consists of one hundred self descriptive statements "which the subject uses to portray his own picture of himself." (Fitts, 1965) The Tennessee Self Concept Scale was originally a composite

of 1) identity, 2) self-satisfaction, 3) behavior, 4) physical self, 5) moral-ethical self, 6) personal self, 7) family self and 8) social self.

Fitts states that:

> "Persons with high scores tend to like themselves, feel they are persons of worth and value, have confidence in themselves and act accordingly: people with low scores are doubtful about their own worth; see themselves as undesirable; often feel anxious, depressed and unhappy; and have little faith or confidence in themselves." (Fitts, 1965)

The scale was normed on a sample of 626 persons with variance in age, sex, race and socioeconomic status. Retest reliability is large enough to warrant confidence in individual difference measurements. Fitts obtained high correlations with others' measures of personality functioning such as the Taylor Anxiety Scale, MMPI, and the Cornell Medical Index. Lambert, Dejulio, and Cole found moderate relationships with Rotter's I-E Scale (1966), Shostrom's Personal Orientation Inventory (1966), and Hohlberg's test of moral development (1964). These results suggest that the Tennessee Self Concept Scale and the above mentioned tests measure similar personality variables. (Fitts, 1965)

The test that the researchers used was a modification of the original Tennessee Self Concept Scale. Modifications that were made were based on a factor analysis of the scale structure of the test. This cut down the number of items and produced eight independent scales. The designated titles for these eight scales are: 1) myself in relation to others, 2) adapting behavior, 3) family relationships, 4) physical body, 5) self disclosure, 6) how I look to others, 7) religion, 8) self-image. Because the researchers are interested in the degree of responsibility people take for their lives and whether or not they feel controlled by internal convic-

tions or external pressures, a test called Rotters Internal/External (I-E) Scale was chosen for use in this study. Subjects were tested to see whether or not they take responsibility for their participation in their disease. Also, are the subjects people (externally or internally controlled) who do choose to attend some sort of adjunctive counseling? With the I-E Scale, these issues will be examined.

In 1957, Phares was the first person to measure individual differences in generalized expectancy, or belief in external control with a Likert-type scale of thirteen internal attitudes and thirteen external attitudes. James, in his dissertation (1957) revised Phares scale, using some of Phares and writing some new items as well as adding some filler items. James hypothesized that "within each of his groups, regardless of chance or skill instructions, those individuals who scored toward the external end of the continuum would behave in each group in the same way as the chance group and the skill group for all subjects." He found low, but significant correlations. (Rotter, 1960) Later, Liverant, Rotter and Seeman undertook the idea of broadening the test by the construction of a new forced-choice questionnaire. This questionnaire version became an instrument consisting of one hundred items with forced-choices. And after being analyzed, they created a twenty-nine-item forced-choice questionnaire, including six filler items intended to create ambiguity as to the purpose of the test.

The I-E Scale was designed to deal with the subjects belief about the nature of the world. Rotter's original subjects were two hundred males and two hundred females and he scored biserial item correlations for both plus a combined correlation. Internally, consistency was rela-

tively stable. Test-retest reliability from one to two months seemed quite consistent. They ranged from .49 to .83. Relationships with test variables, including adjustment, social desirability or need for approval and intelligence are low which indicates good discriminant validity. A group of prisoners were tested and found to have a significantly lower score than college students and this was not expected. Peace Corps volunteers, prior to admittance took the I-E Scale and were highly internally controlled. Hence, believing that this test is a valid and reliable instrument, the researchers used it as part of the testing in the collection of data regarding the personalities of cancer patients.

Finally, the last test that was chosen is the Purpose-In-Life test. In examining the literature, information was found on life satisfaction as it relates to health and health problems. Does health have any influence on life satisfaction? Conversely, it was asked if one's purpose in life could be related to health and health problems and more specifically, cancer.

In examining the literature on life satisfaction (are individuals content with the way that their lives have proceeded?), Palmoe found that the way in which one views one's own health was the most important factor influencing future life satisfaction. In studying life satisfaction, Spreelzes and Snyder (1974) found that an individual's psychological well-being is related to his health condition, socio-economic background and social participation.

In looking for a test it was found that the Purpose-In-Life test, measured slightly differently Frankel's concept of emptiness of purpose of life (see discussion in literature review). Crumbaugh and Maholick

(1964) wanted to measure existential frustration as defined by Frankel. They defined purpose-in-life as a "logical significance of life from the point of view of the experiencing individuals."

In this study, the authors chose 225 individuals and divided them into five groups, from mentally healthy to hospitalized alcoholics. In utilizing the Purpose-In-Life test, they found a significant discrimination between patients and nonpatients. Possession of a substantial degree of purpose seems to be one of the usual properties of normal functioning. There may or may not be a lack of it in the abnormal personality. Crumbaugh and Maholick correlated the results with other tests and found it to measure the same thing as Frankel's questionnaire. (Crumbaugh and Maholick, 1964)

In 1968, Crumbaugh studied 1,151 subjects from normal to psychiatric patients to cross-validate his previous findings and to explore further the relationship of Frankel's "noogenic syndrome" to other traditional syndromes. Crumbaugh utilized the Purpose-In-Life (PIL), MMPI, Srole Anomie Scale and the Minister's Rating Scale for parishioners. Again, he reported a difference between normal and psychiatric patients. Hence, the construct validity of the PIL was well supported. The Minister's Rating Scale for parishioners correlated with the PIL. Also, the Depression Scale of the MMPI correlated with the PIL, but the PIL was not identifiable with any of the conventional mental syndromes. And with the Srole Anomie Scale, a moderate correlation pointed out that the concepts were not the same, but did overlap. The reliability correlation was .88 and with the Spearman-Brown formula it was .92. (Crumbaugh, 1968) With the use of this test, developed by Crumbaugh and Maholick, one could ex-

amine the cancer patient's sense of meaning or purpose in life, as the researchers believe that the test has been well validated.

D. SUBJECTS

The cancer patients who were to participate in this study were selected by the oncologist. He determined who he would contact by getting a list of those patients who had received their diagnosis from six weeks to two months before the beginning of this study or had been seeing him for a recurrent diagnosis for that amount of time. The doctor was limited in his choice, due to the age limit of twenty-one years and older. The doctor also knew that some patients lived so far away that they could not participate even if they wanted to. There was some hesitancy on the doctor's part to call everyone on the list as he felt that everyone was not appropriate for counseling and hence, he did not feel that they would be interested in participating in the study. It was necessary to clarify with him the fact that the researchers were not only looking at people who would be interested in counseling, but also those who were not. However, it continued to be difficult for him to present the study to all the patients objectively and he stated that he presented it with varying degrees of conviction.

The doctor made contact with nine of the participants in person at his office. The other twenty participants were contacted by telephone as they would not be in to the office in a convenient period of time. Those people who the doctor saw in his office signed the participant consent form while the others would sign it when they came for their testing. (See Appendix A for copy of this form.) Information was also presented

to the participants either at the office or by mail, regarding the Kaiser Permanente Cancer Counseling Center.

In contacting the prospective participants the doctor gave the following paraphrased presentation:

> "There are several things that I want to talk to you about. First, I wanted to let you know about the availability of the Kaiser Permanente Cancer Counseling Center in Portland. This center can help you and your spouse or family with the diagnosis of cancer and any related problems. The center is run by Marilyn Friedenbach, a woman who has had breast cancer and is presently doing well. She is able to appreciate the problems one encounters with such a diagnosis and has skills in counseling people with these problems. She offers group sessions as well as a variety of workshops on subjects such as those on relaxation and visualization techniques, on death and dying, life and living, workshops for family members of persons living with cancer, etc. Here is a brochure which explains this center even better. This is available if you feel a need for it--some don't.
>
> The second thing that I wanted to talk to you about is in regard to two graduate students in social work at Portland State University. These two students are doing an interesting study on why people choose to seek out counseling after their diagnosis of cancer. They are looking for cancer patients who are willing to meet with them and take some written tests in the presence of one of them. This will take approximately one hour of your time and shouldn't be stressful to you. The study does not depend on whether or not you go into counseling. I would appreciate it if you would participate in this study and help these two students out."

E. PROCEDURES FOR TESTING

When people agreed to participate in the study, a list of the names and phone numbers of each person was received from the doctor. Each person was contacted for an interview and testing. The meeting place for interviewing varied. Fifteen people were tested at St. Vincent's Hospital, either in Ambulatory Services, or the Social Services Department. Seven of the subjects were tested in their own homes. Three of them were tested at their place of business, one was tested at a local restaurant and two in a waiting room of an orthodontist as that was the only space available. Both

researchers participated in the collection of data. One researcher tested fourteen patients and the other, fifteen.

Each session took approximately one half to one hour of the subject's time. At first, questions were asked from an interview schedule by the researcher. Then the three tests were given and a final question was asked by the researcher regarding the stressful events prior to diagnosis. This was asked last in order not to bias the test results. At the time of testing, each subject was asked if he would like a summary of the study when it was completed.

At the end of six weeks, a follow-up phone call by the same researcher who did the testing was made to determine if the cancer patient had attended any counseling programs. If he had attended a program, he was asked what program and if no program was attended, he was asked why not. (See Appendix F for the Follow-Up Telephone Call Format.)

CHAPTER IV

RESULTS

A. INTRODUCTION

In this study, the main purpose was to determine if personality factors would depict whether or not cancer patients would choose to attend counseling. Other factors involved in why some cancer patients did not choose counseling were also explored. Factors to be examined were the subjects' self-concept, purpose in life, and perceived degree of control in their lives as well as other demographic information about the cancer patients.

In this section, the results will be examined in order to answer the research questions. The first to be reported on will be demographic data including age, sex, marital status, education, income and occupation. The other information compiled will include the first diagnosis of cancer, cancer as described by tissue type, history of relatives with cancer, stress and occupation. Second, the test results for the Internal-External Control test, the Purpose-In-Life test and the Tennessee Self-Concept Scale will be examined. Finally, the other reasons given by the subjects who chose not to attend counseling will be discussed. Twenty-nine subjects were tested. Three of these people died; therefore, only the remaining twenty-six subjects will be used in the statistical analyses.

B. DEMOGRAPHIC DATA

1) Age

The range of ages for those who chose counseling was from twenty-eight to fifty-six years of age. For those who did not choose counseling, the age range was from twenty-one to eighty years of age. Therefore, the non-counseling group had a wider age range. In both groups, the largest number of respondents were in the forty-one to sixty age group. (See Table I, Age) In the counseling group, no subjects were sixty-one or over.

2) Sex

There were five females (83%) and one male (17%) who chose counseling. Of the twenty who did not choose counseling, eleven were females (55%) and nine were males (45%). The majority of the subjects in the counseling group were females. In the noncounseling group, the percentage of males and females was almost equal.

3) Marital Status

The marital status of those in the counseling group consisted of five married subjects and one divorcé. Of those who did not choose counseling, there were sixteen married, two widowed and two divorced persons. In comparing the marital status of both groups, no differences existed. Of the twenty-six cancer patients considered in this study, none were single.

4) Education

In examining the level of education of the subjects there appears to be a slight trend toward more education in the counseling group. (See Table II, Education)

TABLE I

AGE

	Counseling [1]		Non-counseling [2]	
	Frequency	Percent	Frequency	Percent
21 - 40	2	33%	4	20%
41 - 60	4	67%	10	50%
61 - 80	0	0%	6	30%
Totals	6	100%	20	100%

$\bar{x}$ = mean
s = standard deviation

[1] $\bar{x}$ = 46
s = 10.5

[2] $\bar{x}$ = 55.6
s = 15.3

TABLE II

EDUCATION

	Counseling		Non-counseling	
	Frequency	Percent	Frequency	Percent
High School	1	17%	8	40%
Technical School	1	17%	1	5%
Some College	2	33%	6	30%
College Graduate	2	33%	4	20%
Graduate School	0	0%	1	5%
Totals	6	100%	20	100%

5) Income

In looking at Table III, Income, one can note that the family income for the noncounseling group is distributed in proportionately the same way as for the counseling group.

6) First Diagnosis of Cancer

Of the six subjects who chose counseling, four subjects (67%) said that it was their first diagnosis of cancer. Two subjects (33%) said that it was not their first diagnosis. Of the twenty who did not choose counseling, fourteen subjects (70%) said that it was their first diagnosis of cancer and six (30%) said that it was not their first diagnosis. With this small amount of subjects, there is not much difference between the two groups. Some of the subjects who had had a diagnosis of cancer prior to this one, said that they might have gone for counseling at the time of their first diagnosis if they had known about it.

7) Cancer Described by Tissue Type

The number of subjects in the cancers as described by tissue type, differed for both groups. In the counseling group, only breast cancer and lymphoma (cancer of infection fighting organs) existed. All of the following types of cancer were exhibited in the noncounseling group. Two or more subjects had diagnoses of lymphoma, breast cancer, genito-urinary cancer (including cancer of the cervix and ovaries), lung cancer, hematologic cancer (including leukemia and myeloma), and gastro-intestinal cancer (including cancer of the colon, the liver and the stomach). (See Table IV, Cancer Described by Tissue Type)

TABLE III

INCOME

	Counseling		Non-counseling	
	Frequency	Percent	Frequency	Percent
No Response	0	0%	2	10%
0 - 4,999	0	0%	2	10%
5 - 9,999	1	17%	0	0%
10 - 14,999	1	17%	5	25%
15 - 19,999	0	0%	3	15%
20 +	4	66%	8	40%
Totals	6	100%	20	100%

TABLE IV

CANCER DESCRIBED BY TISSUE TYPE

	Counseling		Non-counseling	
	Frequency	Percent	Frequency	Percent
Lymphoma	3	50%	5	25%
Breast	3	50%	3	15%
Genito-urinary	0	0%	3	15%
Lung	0	0%	2	10%
Hematologic	0	0%	3	15%
Gastro-intestinal	0	0%	4	20%
Totals	6	100%	20	100%

8) History of Relatives with Cancer

In questioning the subjects as to how many relatives in their families had cancer, the subjects from each group reported similar amounts of cancer history in their families. (See Table V, History of Relatives with Cancer)

9) Occupation

The occupations of the subjects included homemakers, retired persons, nonprofessionals (such as salespersons, a loan officer, an appliance technician, a carpenter, a legal secretary, a cabin maker, a freight agent, a bookkeeper, and an industrial executive) and professionals (such as a lawyer, a CPA, a teacher and a nurse). In the counseling group, there seems to be a trend for one's occupation to be a homemaker. The trend in the noncounseling group might be towards nonprofessional occupations. (See Table VI, Occupation)

10) Stress

In the interview situation, the researchers asked the subjects what kinds of stress they felt they had experienced prior to the onset of their diagnosis of cancer. Responses to this question ranged from denial of any kind of stress to a number of stressful life events. For example, new marriages were cited as stressful, as well as changes in jobs, buying a new home, death of a family member, discipline problems with children, added responsibilities at home, other health problems of their own or of family members, and children moving away from home. Due to inconsistent questioning at the time of the interviews, the depth of responses varied in such a way that it would be very difficult to evaluate these responses accurately.

TABLE V

HISTORY OF RELATIVES WITH CANCER

	Counseling		Non-counseling	
	Frequency	Percent	Frequency	Percent
0 relatives	1	17%	5	25%
1 relative	1	17%	5	25%
2 relatives	2	33%	8	40%
3 + relatives	2	33%	2	10%
Totals	6	100%	20	100%

TABLE VI

OCCUPATION

	Counseling		Non-counseling	
	Frequency	Percent	Frequency	Percent
Homemaker	3	50%	6	30%
Retired	0	0%	1	5%
Nonprofessional	2	33%	9	45%
Professional	1	17%	4	20%
Totals	6	100%	20	100%

C. RESULTS FROM THE TEST SCORES

1) The Purpose-In-Life test results produced approximately the same mean score and standard deviation for the counseling and noncounseling groups. (See Table VII, Internal-External Control and Purpose-In-Life Test Scores)

2) The Rotter's Internal-External Control Scale, which is scored according to the number of external responses, elicited a similar mean score for the counseling and the noncounseling groups, but reported a wider variance in standard deviations. (See Table VII, Internal-External Control and Purpose-In-Life Test Scores)

3) The test results from the Tennessee Self-Concept Scale were divided into the eight scales discussed in Chapter III. The responses reported were similar for both groups. (See Table VIII, Tennessee Self-Concept Scale Scores)

D. DISCRIMINANT FUNCTION ANALYSIS

Two discriminant function analyses were computed to determine if individuals would be assigned to the counseling or noncounseling groups on the basis of the stated variables alone. The first discriminant used five demographic variables including age, sex, marital status, education and income as well as first diagnosis of cancer, history of relatives with cancer and medical treatment received for the cancer. The other variables also included in this discriminant function were the Purpose-In-Life test scores, the Rotter's Internal-External Control test scores, and the eight Tennessee Self Concept Scale scores. The second analysis was done only on the tests. No significant relationships existed in

TABLE VII

INTERNAL-EXTERNAL CONTROL & PRUPOSE-IN-LIFE TEST SCORES

	Counseling		Non-counseling	
	$\bar{x}$	s	$\bar{x}$	s
Internal-External Control	5.6	1.8	6.5	3.3
Purpose-In-Life Test	105.5	14.7	111.4	11.5

TABLE VIII

TENNESSEE SELF CONCEPT SCALE SCORES

	Counseling		Non-counseling	
	$\bar{x}$	s	$\bar{x}$	s
Myself in Relation to others	21.3	3.5	19.8	3.0
Adapting Behavior	26.6	6.4	29.6	3.6
Family Relationships	30.1	2.9	32.1	2.1
Physical Body	29.8	3.4	28.6	4.4
Self Disclosure	18.5	3.8	18.2	3.4
How I look to others	20.5	2.4	20.0	2.6
Religion	13.6	1.7	13.4	3.9
Self Image	16.8	2.1	16.2	3.5

either analysis. This information indicates that the demographic characteristics and personality variables measured by the chosen tests could not be used to determine if cancer patients will or will not choose to attend counseling.

E. FOLLOW-UP PHONE CALL

At the six week follow-up telephone call, each subject was asked if he chose to attend counseling or not. Those subjects who chose not to attend counseling were asked why they did not attend any counseling programs. (See format for phone call in Appendix F) Nine categories of reasons were given by those twenty subjects. (See Table IX, Distribution of Responses to the Follow-Up Questions for Those Who Chose Not to Attend Counseling) First, the response given the most was that the patients did not feel that they needed counseling. Another response that was given was simply a desire to forget the past. By attending counseling, this person did not feel that he could do that. One person was unable to get to the counseling center due to his physical condition and also felt that a one hour counseling session would be too mentally exhausting. Several subjects reported that they had enough emotional support from their friends and family. Being too busy to attend counseling was another response given by some of the subjects. Others felt that they got enough support from their church with their own religious convictions giving them the strength that they needed. One person questioned the validity of this counseling program. Several people reported being influenced by the doctor in their decision regarding counseling. Some examples of responses in this category include the following: "The

TABLE IX

DISTRIBUTION OF RESPONSES TO THE FOLLOW-UP QUESTIONS FOR THOSE WHO CHOSE NOT TO ATTEND COUNSELING

Responses		Non-counseling			
		Number of Responses			
Response number		3	2	1	Total
		n=4	n=7	n=9	N=20
1	Not need it	3	5	6	14
2	Forget past	0	0	1	1
3	Not have physical/mental capacity	0	1	0	1
4	Support from others	3	1	0	4
5	Busy	2	3	0	5
6	Support from church	3	0	1	4
7	Question validity of counseling program	0	0	1	1
8	Doctor's influence	0	4	0	4
9	Too far a distance	1	0	0	1

Combinations of Responses					
3 Responses		2 Responses		1 Response	
Response #	Number of Responses	Response #	Number of Responses	Response #	Number of Responses
1,4,6	2	1,8	2	1	6
1,5,9	1	1,5	3	6	1
4,5,6	1	3,8	1	7	1
		4,8	1	2	1

doctor did a lot of counseling himself.", "The openness of the doctor was most helpful in dealing with the diagnosis of cancer.", "If the doctor had told me to go for counseling, I would have gone.", "The doctor did not think that I would need counseling." Finally, one subject stated that the counseling service was too far away. From this follow-up contact, it appeared that the five most significant responses consisted of not feeling that they needed it, receiving enough support from the church and others, being too busy and being influenced in some way by the doctor.

F. CONCLUSION

It is not possible to discriminate between the two groups, based on the demographic data and the tests. At this point, nothing can be postulated that will determine if a cancer patient from this group will or will not choose to attend counseling. It appeared that the five main responses from the follow-up phone calls suggest that other factors (besides demographic data and these tests) influence whether or not cancer patients choose to attend counseling.

CHAPTER V

DISCUSSION

A. INTRODUCTION

In this chapter, some of the issues which developed out of this study will be discussed. The researchers would like to elaborate on the findings and discuss some of the conclusions they have drawn from the results as well as to present their interpretations of these facts. The limitations of this study will also be delineated with some recommendations proposed for further study.

B. CONCLUSIONS

The research question which was posed in this study was just what, if any, personality factors are involved in the determination of who would choose to seek adjunctive counseling in dealing with his life-threatening disease or other problems that may arise around his illness. Questions were asked of those who did not choose to attend counseling in order to get a better understanding of those reasons people had for non-attendance.

The results of this study indicate that personality characteristics do not predict whether or not a cancer patient will choose to attend counseling. The findings from the interview schedule also showed that demographic statistics were not significantly different between the two groups (attenders and non-attenders). However, a trend existed for those who attended counseling. The counseling group had a smaller age range,

proportionately more females, higher educational level, more professional training and a smaller variety of cancer diagnoses. Interestingly enough, no single never married subjects existed in either group. The main factors which explain why twenty of the twenty-six cancer patients chose not to attend counseling included not feeling that they needed it, receiving enough support from the church and others, being too busy and being influenced in some way by the doctor.

C. INTERPRETATIONS

When considering the sex of the subjects in this study, one can see that the trend was for females to attend counseling more than males. Generally, more women do go to counseling than do men. One reason for this might be that those who are homemakers are more able to take the time to attend some kind of counseling program. One other reason why more women may attend counseling than men is that culturally, women are expected to be the affective ones, to show emotions and to cry and hence, a counseling situation might be less threatening for them.

With none of the subjects being single, one might speculate that less single people than others seek out private oncologists for their care. One could also conjecture that single people might not have the same cancer incidence as married people. Perhaps the marriage state creates stress which leads to susceptibility to disease. This area would be interesting for further study.

The educational level of participants in counseling who have cancer is still an interesting subject. Two thirds of those who sought counseling in this study had some college education as compared to approximately one-half of those non-attenders. In the counseling program developed by Si-

montons, the average educational level is 17.1 years. (This figure includes children involved in their program.) The average educational level for this study was less than that of the Simonton's program. One might still conjecture that the more education one has, the more flexible and motivated one might be toward getting involved in counseling.

Studies have also shown that income is high for persons who attend counseling, in general. This might simply be due to the fact that these people are more highly educated and hence, have higher paying jobs. Again, one can hypothesize that the higher the total family income, the greater chance that the woman can maintain her role as a homemaker and therefore, be freer to attend counseling during the day.

Counseling can be costly and this, too, deters many people from entering into it. Newly developing counseling programs for cancer patients now in the Portland area are being offered for little or no cost which, hopefully, will eliminate this financial deterrent.

In this study only people who had breast cancer or lymphoma sought counseling. One may speculate that this may be due to the fact that people are more educated about these diagnoses than other diagnoses. The increased knowledge about these diagnoses has lowered the stigma level involved and hence, freed people up to speak more openly about such cancer types and the effect on their lives. Many support services and counseling programs are also offered for women who have had mastectomies which shows the trend for society to be more accepting of the needs and traumas of individuals undergoing this surgery and/or these women may be more willing to take responsibility for themselves. Many of the cancer counseling programs offered are run by people who, themselves, have had cancer. Knowing

this, patients might feel freer to relate some of their own experiences, fears, frustrations, etc. in a counseling session.

Despite the fact that in this study no significant differences existed in the group's purpose in life, there were interesting comments made by some of the subjects regarding this and their will to live. Many had decided to keep on working as usual and to fight the disease because they had things that they needed and wanted to do yet in life. This positive attitude and determination regarding recovery from the cancer is, in itself, instrumental in treatment of the disease. On the other hand, many were not ready to examine, via counseling, what was happening in their lives.

No differences in test scores were found between the two groups on the Rotters Internal-External Control test or the Tennessee Self Concept Scale. Contrary to what some studies in the review of the literature cited, the cancer patients in either group did not vary significantly in their own level of internal versus external control of their lives. Even in the eight scales of the Tennessee Self Concept Scale that were examined, including one's identity, self-satisfaction, behavior, physical self, moral-ethical self, personal self, family self and social self, there were no differences found between the two groups.

D. LIMITATIONS

Several important limitations of this study will be discussed. First, the doctor's influence will be examined. The size of the sample and the difference in interviewer techniques also affected the results of this study and therefore will be discussed.

In the researcher's opinion, the doctor is the most important person in a research study such as this. It is he who affects his patients, their thoughts and feelings about their disease and what they decide to do about their disease. As discussed in the literature review, Peck (1972) states that patients very often do identify with the doctor and look to him for strength and even healing powers. Hence, as in past studies which have been done, the researchers found that the doctor holds a very influential position in the lives of his patients.

The doctor in this study is a humanistic, thoughtful human being. This may not be helpful, however, to the research, which looks for objectivity. The subjects indicated to the researchers that they received different information about the counseling programs available. Some patients said that they did not know about the programs. Two of them indicated that the doctor thought they did not need counseling at that point and therefore, they did not pay much attention to what was available. The doctor did, in fact, tell the researchers that he shared information regarding the counseling services available, with varying degrees of conviction. This inconsistency of contact of the doctor and his patients may have influenced whether or not the patients chose counseling. Consistency is important in any research and is one of the main problems in research with human beings. Having the doctor present this information to the patients in a variety of ways was, therefore, one limitation in this study.

Because of his humanistic, sensitive approach, one might speculate that to this extent, the doctor does his own counseling for his patients. Consistent with what was reported in the literature review by Miller (1977),

this doctor saw the need to tell the patients the truth about their disease and to help them to deal with their attitude toward the cancer as it is assumed that this affects the prognosis. One patient told the researchers about his lengthy talks with the doctor which provided him with the support and information he needed to relieve his anxiety. Other patients talked about their strong regard for the doctor and his concern for them as people. One person who did not attend counseling said that he "would have gone if the doctor had told him to go." At the onset of a life crisis, whoever the first contact person is may have a tremendous impact on the whole situation. The cancer patient may develop a strong relationship with the doctor and might feel that he was questioning the doctor's adequacy by transfering that bond to the counselor. It might also be true that the individual could only develop a relationship with one individual at a time. This may be an indication of his ability to develop relationships in general.

Another limitation of this study was the small total sample size as well as the limited number in the counseling group. It was difficult to obtain subjects for this study. Working with one doctor lowered the number of patients accessible and interested in this study. Of the twenty-nine people involved in the study, three died. Of the three that died, their spouses said that they had talked about the counseling and all had agreed to attend. Time or distance interfered with their ability to attend, however. One might speculate that this plan to attend counseling could be a response to their desperation regarding their illness or to the finality of death. A larger number of subjects would help the accuracy of the results.

Another problem was with the number of variables. Using three tests was not helpful. One test would have been sufficient, depending on the focus of the research. Also, cutting down the demographic variables would help tighten up the research design. For example, if the researchers looked at all married women with breast cancer who were homemakers, came from upper middle-class families and had at least a college education, they would be more able to utilize the results and to make inferences about the sample of the population.

Differences in the interviewers' style influenced the way in which the subjects responded in the interview situation. One researcher tended to be more businesslike or professional and the other tended to be more casual and less consistent in her depth of questioning during the interview, depending on the openness of the interviewee. Hence, as with the doctor, the approaches to the subjects varied and therefore, more or less information was received from them during the time of the interview, depending on who the researcher was.

Along with these problems, the place of testing varied and this could influence the results of the study. For example, those who took the tests in their own homes might have been less nervous than those who came into the hospital's Ambulatory Services to take the tests.

E. RECOMMENDATIONS

After completing this study the researchers were concerned with further research in the areas of cancer, personality and counseling. In this section, recommendations for further research will, therefore, be postulated. These will be based upon what the researchers learned during

this study. Recommendations for those who offer counseling programs and to doctors in their work with these patients will also be suggested.

First, the stigma attached to counseling must be overcome by all those involved, including the doctor, the researchers, the patients, and anyone else involved. One way to do this might be to set up an educational component designed to bring awareness to the public as to what counseling is, what its goals are, etc. The educational component could consist of tapes or video-tapes which would present this information in a positive, consistent way. That way, the same information would be received by all of the subjects. The focus of the tapes could be to change atttitudes about counseling, to realize who can benefit from counseling and to increase awareness and knowledge of holistic health concepts.

To create a more rigorous design, one could reduce the variables and increase the sample size. Increasing the number of doctors in the sample would increase the accessibility to patients. This would be necessary especially if the criteria for participation in the study were more stringent. More doctors does increase the number of variables, however.

In order to help prevent interviewer bias, one interviewer could be used for all the interviews obtained. That would decrease the inconsistent results due to the difference in personalities and interviewing styles of the researchers. If this weren't possible, more training for the interviewers would need to be done to increase reliability.

For those individuals who offer counseling programs, the researchers would like to offer the following recommendations: First, more evening programs and weekend groups, workshops etc. This would allow many of the working cancer patients the opportunity to attend. Many of the patients

live too far away to come to the inner city of Portland for counseling and therefore a variety of locations for these services are needed. They might be held in schools, rural community mental health centers or town halls. Second, the fact that these programs do exist needs to be publicized even more. This could be done through newspaper ads, mailed bulletins such as the Kaiser Permanente Counseling Center mailout (Options) or more shared information within health care institutions as to what is available. Third, it would be to the counseling program's advantage to have the support of the physicians who deal with these patients. Their influence, especially with the male patients, can be helpful in increasing those patient's responsiveness to such programs.

To the physicians then, the researchers would like to suggest the following recommendation: when at the time of diagnosis the doctor might consider inviting family members and taping the session as Dr. Rosenbaum of Mt. Zion Hospital in San Francisco suggested, to alleviate the selected hearing which occurs in this session by the patient and his family. At the time of a followup appointment, the doctor could tell the patient and his family about alternative support services and counseling programs available. This could be done via an educational video-tape or tape cassette in the doctor's office if the doctor did not want to spend a lot of time dealing with that. The doctor's attitude toward these programs, however, and his simple acknowledgement of the need to care for one's total being, not just the physical being, can be enough to stimulate thought, consideration and validation on the patient's or family's part to seek out some form of adjunctive counseling.

If counseling programs continue to increase in number and variety as they appear to be doing, patients will have more opportunity to get

involved in such programs. Holistic health concepts, as they are expanding and being developed, will create new images and awarenesses for the mind and the body. This may help motivate cancer patients to examine the whole entity and how it is related, and in fact, encourage many cancer patients to attend counseling.

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APPENDIX A

PARTICIPANT CONSENT FORM

Dr. _____ has explained to me that research is being done by Ms. Jan March and Ms. Ann Maxwell, Graduate students from the School of Social Work, Portland State University, with cancer patients. I understand that the study has been undertaken to increase the knowledge about cancer patients at this clinic. The study will consist of a brief questionnaire, tests, and interview.

By participation in this study, I agree to meet with one of the researchers for approximately one hour to do the testing. All of my test results will be kept confidential. The results will be reported as a group with no names used. I understand that I may withdraw my consent and discontinue participation in this study at any time or for whatever reason. I understand that if I do withdraw, it will in no way affect my medical care.

I hereby agree to participate in the above stated study, receiving a written summary of the results of the study once completed.

Signature of Participant _____
date

Signature of Witness _____
date

_____
(Doctor's Signature)

_____
date

APPENDIX B

QUESTIONNAIRE

NUMBER_____ DATE_____

BIRTHDATE_____ SEX_____

MARITAL STATUS:_____SINGLE _____MARRIED _____DIVORCED
_____WIDOWED

RACE_____

EDUCATION: WHAT IS THE HIGHEST LEVEL OF EDUCATION YOU HAVE ACHIEVED?
_____

OCCUPATION:_____

INCOME LEVEL:
PROBE: $00.00-$5000
$5-9000
$10-14000
$15-19000
$20,000+

HISTORY DO YOU HAVE ANY HISTORY OF CANCER IN YOUR FAMILY?
PROBE: IMMEDIATE FAMILY
PARENTS
GRANDPARENTS

ARE YOU RECEIVING MEDICAL TREATMENT? IF SO WHAT TREATMENT ARE YOU RECEIVING?_____

WHAT IS THE LOCATION OF YOUR CANCER?_____

IS THIS THE FIRST TIME YOU HAVE HAD CANCER?_____

TO BE ASKED AFTER TESTS HAVE BEEN TAKEN:

STRESS: HAVE YOU HAD ANY STRESSFUL EVENTS THAT HAVE OCCURRED IN THE LAST 18 MONTHS BEFORE YOUR CANCER DIAGNOSIS?

PROBE: LOSSES
DEATHS
CHANGES IN JOB
CHANGES IN PERSONAL LIFE
CHANGES IN LIVING SITUATION

APPENDIX C

PURPOSES TEST

Part A

For each of the following statements, circle the number that would be most nearly true for you. Note that the numbers always extend from one extreme feeling to its opposite kind of feeling. "Neutral" implies no judgment either way; try to use this rating as little as possible.

1. I am usually:

1	2	3	4	5	6	7
completely bored			(neutral)			exuberant, enthusiastic

2. Life seems to me:

7	6	5	4	3	2	1
always exciting			(neutral)			completely routine

3. In life I have:

1	2	3	4	5	6	7
no goals or aims at all			(neutral)			very clear goals and aims

4. My personal existence is:

1	2	3	4	5	6	7
utterly meaningless without purpose			(neutral)			very purposeful and meaningful

5. Every day is:

7	6	5	4	3	2	1
constantly new and different			(neutral)			exactly the same

6. If I could choose, I would:

1	2	3	4	5	6	7
prefer never to have been born			(neutral)			like nine more lives like this

7. After retiring, I would:

7	6	5	4	3	2	1
do some of the exciting things I have always wanted to do			(neutral)			loaf completely the rest of my life

8. In achieving life goals I have:

7	6	5	4	3	2	1
made no progress whatever			(neutral)			progressed to complete fulfillment

9. My life is:

1	2	3	4	5	6	7
empty, filled only with despair			(neutral)			running over with exciting good things

10. If I should die today, I would feel that my life has been:

7	6	5	4	3	2	1
very worthwhile			(neutral)			completely worthless

11. In thinking of my life, I:

1	2	3	4	5	6	7
often wonder why I exist			(neutral)			always see a reason for my being here

12. As I view the world in relation to my life, the world:

1	2	3	4	5	6	7
completely confuses me			(neutral)			fits meaningfully with my life

13. I am a:

1	2	3	4	5	6	7
very irresponsible person			(neutral)			very responsible person

14. Concerning man's freedom to make his own choices, I believe man is:

7	6	5	4	3	2	1
absolutely free to make all life choices			(neutral)			completely bound by limitations of heredity and environment

15. With regard to death, I am:

7	6	5	4	3	2	1
prepared and unafraid			(neutral)			unprepared and afraid

16. With regard to suicide, I have:

1	2	3	4	5	6	7
thought of it seriously as a way out			(neutral)			never given it a second thought

17. I regard my ability to find a meaning, purpose, or mission in life as:

7	6	5	4	3	2	1
very great			(neutral)			practically none

18. My life is:

7	6	5	4	3	2	1
in my hands and I am in control of it			(neutral)			out of my hands and controlled by external factors

19. Facing my daily tasks is:

7	6	5	4	3	2	1
a source of pleasure and satisfaction			(neutral)			a painful and/or boring experience

20. I have discovered:

1	2	3	4	5	6	7
no mission or purpose in life			(neutral)			clear-cut goals and a satisfying life purpose

APPENDIX D

ROTTER'S INTERNAL-EXTERNAL CONTROL TEST

NUMBER_____

Directions: Each question contains two statements. Circle the letter a, or b. depending on which statement seems more true to you.

1. a. Children get into trouble because their parents punish them too much.
   b. The trouble with most children nowadays is that their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are partly due to bad luck.
   b. People's misfortunes result from the mistakes they make.

3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.
   b. There will always be wars, no matter how hard people try to prevent them.

4. a. In the long run people get the respect they deserve in this world.
   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. a. The idea that teachers are unfair to students is nonsense.
   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. a. Without the right breaks one cannot be an effective leader.
   b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. a. No matter how hard you try some people just don't like you.
   b. People who can't get others to like them don't understand how to get along with others.

8. a. Heredity plays the major role in determining one's personality.
   b. It is one's experiences in life which determine what they're like.

9. a. I have often found that what is going to happen will happen.
   b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.
    b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
    b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.
    b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.
    b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. a. There are certain people who are just no good.
    b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.
    b. Many times we might just as well decide what to do by flipping a coin.

16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
    b. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
    b. By taking an active part in political and social affairs the people can control world events.

18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
    b. There really is no such thing as "luck".

19. a. One should always be willing to admit mistakes.
    b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.
    b. How many friends you have depends upon how nice a person you are.

21. a. In the long run the bad things that happen to us are balanced by the good ones.
    b. Most misfortunes are the result of lack of ability, ignorance, laziness or all three.

22. a. With enough effort we can wipe out political corruption.
    b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.
    b. There is a direct connection between how hard I study and the grade I get.

24. a. A good leader expects people to decide for themselves what they should do.
    b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.
    b. Its impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.
    b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There's too much emphasis on athletics in high school.
    b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.
    b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.
    b. In the long run the people are responsible for bad government on a national level as well as on a local level.

APPENDIX E

TENNESSEE SELF CONCEPT SCALE-MODIFIED FORM

		Responses				
		Completely false	Mostly false	Partly false & partly true	Mostly true	Completely true
		1	2	3	4	5
1.	I have a healthy body----	1	2	3	4	5
3.	I am an attractive person	1	2	3	4	5
19.	I am a decent sort of person----------	1	2	3	4	5
21.	I am an honest person----	1	2	3	4	5
23.	I am a bad person--------	1	2	3	4	5
37.	I am a cheerful person---	1	2	3	4	5
55.	I have a family that would always help me in any kind of trouble----------	1	2	3	4	5
57.	I am a member of a happy family----------	1	2	3	4	5
73.	I am a friendly person---	1	2	3	4	5
91.	I don't always tell the truth----------	1	2	3	4	5
93.	I get angry sometimes----	1	2	3	4	5
2.	I like to look nice and neat all the time--------	1	2	3	4	5
4.	I am full of aches and pains	1	2	3	4	5
6.	I am a sick person-------	1	2	3	4	5

		Completely false	Mostly false	Partly false & partly true	Mostly true	Completely true
		1	2	3	4	5
20.	I am a religious person-	1	2	3	4	5
22.	I am a moral failure----	1	2	3	4	5
24.	I am a morally weak person----------	1	2	3	4	5
58.	I am not loved by my family----------	1	2	3	4	5
60.	I feel that my family doesn't trust me--------	1	2	3	4	5
78.	I am hard to be friendly with----------	1	2	3	4	5
7.	I am neither too fat nor too thin----------	1	2	3	4	5
9.	I like my looks just the way they are----------	1	2	3	4	5
27.	I am satisfied with my relationship to God-----	1	2	3	4	5
29.	I ought to go to church more----------	1	2	3	4	5
61.	I am satisfied with my family relationships----	1	2	3	4	5
63.	I understand my family as well as I should--------	1	2	3	4	5
95.	I do not like everyone I know----------	1	2	3	4	5
97.	Once in a while, I laugh at a dirty joke---------	1	2	3	4	5
26.	I am as religious as I want to be----------	1	2	3	4	5
28.	I wish I could be more trusting----------	1	2	3	4	5

		Completely false	Mostly false	Partly false & partly true	Mostly true	Completely true
		1	2	3	4	5
30.	I shouldn't tell so many lies----------	1	2	3	4	5
48.	I wish I didn't give up as easily as I do------	1	2	3	4	5
82.	I should be more polite to others----------	1	2	3	4	5
96.	I gossip a little at times----------	1	2	3	4	5
13.	I take good care of myself physically-------	1	2	3	4	5
15.	I try to be careful about my appearance---------	1	2	3	4	5
85.	I try to understand the other fellow's point of view----------	1	2	3	4	5
89.	I do not forgive others easily----------	1	2	3	4	5
99.	I would rather win than lose in a game---------	1	2	3	4	5
14.	I feel good most of the time----------	1	2	3	4	5
54.	I try to run away from my problems----------	1	2	3	4	5
68.	I do my share of work at home----------	1	2	3	4	5
72.	I don't act like my family thinks I should--------	1	2	3	4	5
88.	I do not feel at ease with other people----------	1	2	3	4	5
90.	I find it hard to talk with strangers---------	1	2	3	4	5

APPENDIX F

FOLLOW-UP TELEPHONE CALL FORMAT

Hello

This is _____ calling. I am working with _____ on the cancer study with Dr. Goldman. I am calling to find out whether you have ever gone to the Cancer Counseling Center or any counseling programs.

If so, what program and where?

If not, what are the reasons you have chosen not to go to counseling?

Probe:
- transportation
- work
- too sick
- family meets needs
- nothing appropriate available