

## CHAPTER 4

# CANCER AND APPLIED THEORETICAL FRAMEWORKS: COPING, PERSONALITY AND PROCESS THEORY.

### 4.1 Introduction

The experience of breast cancer and/or the recurrence of breast cancer seem to depend largely on how people react to the diagnosis. This reaction is closely related to their coping mechanisms and possibly their personalities. In the previous chapter an outline is given to provide a broader understanding of how people learn within a social world. In this chapter, a more specific outline of theories explaining how people cope and what factors influence this coping behaviour, is presented.

To come to an understanding of coping, a brief description of the development of coping theories is given to illustrate why a specific coping theory has been chosen as theoretical framework to study the experience of breast cancer and its recurrence. Emphasis is placed on theories that may be applicable to coping with a chronic disease such as cancer. Theoretical issues underlying behaviour such as denial and information seeking behaviour, which are prominent in coping with cancer, are discussed. In psycho-oncological research theories are formulated alongside practical findings from studies. It is difficult to separate the two and a better understanding of how a specific theory is chosen above another is better illustrated by showing how conclusions from one study lead to a more refined theory which is better suited to the study of the experience of being a cancer patient.

Reasons for studying theories about coping are numerous. Newman (1990) stated that researchers study coping behaviour in an attempt to make sense of the different responses to illness and stress as well as differences in outcomes in the disease

process. A better understanding of the concept might permit the development of appropriate interventions to enhance constructive coping styles and ameliorate problems experienced by people whom employ maladaptive or ineffective strategies.

## 4.2 Coping: overview of state/trait approach

There are mainly two broad approaches describing the theoretical concept of coping. The first emphasised style (Pettingale, Burgess & Greer 1988; Eysenck, 1985; Weinberger, Swartz & Davidson, 1979). They described coping as a personality characteristic. The other theory, described by Lazarus (1993) emphasised process; that is, efforts to manage stress that change over time and are shaped by the adaptational context out of which it is generated. The process theory of Lazarus is also more applicable to the qualitative approach of this study, which emphasises the relationship between the individual and herself; the individual and others around her; the individual and the disease.

As with stress, coping has been defined in many different ways. Although the process theory of Lazarus (1993) is the theoretical framework against which the psychological impact of the news of recurrence is studied here, an overview of other approaches as applied to the way patients react to the news that they have cancer, is given. A critique of other approaches to coping is done to illustrate why the Lazarus theory seems to be the most suitable theory to examine coping with cancer.

An approach that separated the coping behaviour of individuals into different strategies which are described as fixed ways of dealing with cancer, were used by Greer and Watson (1987). They defined mental adjustment to cancer as the cognitive and behavioural responses made by an individual to the diagnosis of cancer. Mental adjustment comprises firstly appraisal, that is, how the patient perceives the implications of cancer, and secondly the ensuing reactions which entails what the

patient thinks and does to reduce the threat posed by cancer. These fixed ways of dealing with the threat posed by cancer might also have an influence on the eventual outcome of the disease. Greer and Watson developed a mental adjustment to cancer scale, which followed the original work done by Morris, Greer, Pettingale and Watson (1981), Watson, Greer, Young, Inayat, Burgess and Robertson (1988) and Osborne, Elsworth, Kissane, Burke and Hopper (1999), who refined the scale further. This scale groups mental adjustment to cancer into four broad categories, namely:

- (i) Fighting spirit. This categorises people who fully accept a diagnosis of cancer, have an optimistic attitude towards it and are determined to fight it.

Fallowfield and Clark (1991) found many examples of fighting spirit in one thousand in-depth interviews conducted with cancer patients. An example from their book on breast cancer is *"I'm not giving in, whatever happens. I'm going to fight this thing"* (p 41).

- (ii) Denial. The patient either rejects the diagnosis of cancer or denies/minimises its seriousness. Denial is something that I encountered many times in my work with cancer patients. They would, for example, say: *"Well, I don't think that these experts always know what's going on and just to be on the safe side they prefer to treat breast lumps as serious, just in case"* (Fallowfield & Clark, 1991, p 41).

- (iii) Stoic acceptance. The patient accepts the diagnosis, does not seek further information and has a fatalistic attitude. An example of such an attitude would be: *"I knew what he was going to say. I was quite prepared. I know that it's out of my hands - what will be, will be. It's pointless worrying"* (Fallowfield & Clark, 1991, p 42).

(iv) Helplessness/hopelessness The patient is overpowered by the knowledge of the diagnosis and her daily life is disrupted by the preoccupation with cancer and dying. Another quote from Fallowfield and Clark (1991) illustrated this attitude as follows: "*We're not lucky people in our family - my Dad died of cancer, and my Mum. I know I'm going to go that way too. The only thing I like is my garden, but I haven't planted any bulbs even - what's the point? I won't see them will I?*" (Fallowfield & Clark, 1991, p 41).

Using the Mental Adjustment to Cancer Scale (MAC), Greer and Pettingale (1979) reported results which indicated that psychological response to cancer diagnosis, assessed three months post-operatively, were related to outcome five years later.

Ten years later, Pettingale, Morris, Greer, and Haybittle (1985) re-examined the association between psychological response and outcome in their cohort of patients. They found, once again, a more favourable outcome in those patients described as exhibiting fighting spirit and denial than among those who showed stoic acceptance or a helpless/hopeless response. They came to the conclusion that the effect of mental attitude is independent of other prognostic factors and should be included as an additional prognostic indicator for patients with breast cancer.

Burgess, Morris and Pettingale (1988) did further research that confirmed the existence of these four broad categories. Their analysis of cognitive responses and the other psychological variables combined, also revealed that four broad coping styles could be delineated: positive/confronting, fatalistic, hopeless-helpless and denial/avoidance. These categories corresponded to their previously described categories. Lower psychological morbidity was associated with a positive/confronting response to diagnosis and with high internal locus of control, while higher anxiety and depression scores were associated with a hopeless-helpless response to diagnosis and with low internal locus of control.

Other researchers also used the same categorisation of mental adjustment to cancer. Grassi, Rosti, Lasalvia and Marangolo (1993) investigated the role of psychosocial variables and psychological vulnerability on adjustment to cancer. Their study was undertaken on 157 cancer patients. Assessment of adjustment to cancer was carried out with the Mental Adjustment to Cancer, (MAC) scale. The results indicated that the MAC dimension Fighting Spirit (FS) was related to low External locus of control (ELC) and high social support, while an opposite association was shown for Helplessness (H) and Fatalism (F). According to MAC cut-off scores, 'cases' reported higher ELC and lower social support than 'non-cases'. Their findings seem to confirm the utility of the MAC in oncological settings and the adverse effect of prior psychological problems, present emotional disorders, external locus of control and inadequate interpersonal support on strategies of adjustment to cancer.

Another study, by Ralph, Clemente and Temoshok (1985) used the same theoretical framework for studying adjustment to having malignant melanoma as a predictor of follow-up clinical status. The study involved 117 patients who were followed up longitudinally. A clinical psychologist interviewed patients on their first clinic visit following diagnosis. The interview included questions regarding the patients' adjustment to the disease. Two independent researchers, using two categorization schemes, coded the patients' responses to the questions concerning their reaction to malignant melanoma. The Greer and Watson (1987) categorisation assigned patients to one of four mutually exclusive adjustment categories (denial, fighting spirit, stoic acceptance and feelings of hopelessness/helplessness). The second procedure derived a quantitative measure for each of the four categories, thus yielding a profile of scores. Contingency table and logistic regression analysis identified two statistically significant gender-specific predictors of clinical status. Response characteristics of stoicism among women and helplessness/hopelessness among men were significantly associated with unfavourable outcome. Their findings support

previous research, suggesting that psychological adjustment, even when known biological and epidemiological prognostic determinants are evaluated in the analysis, may be a significant predictor of clinical status.

Coping strategies that have been studied extensively and separately from the Greer and Watson categorisation are denial versus confrontation and information seeking versus information-avoiding behaviour.

### 4.3 Denial

As with the other coping strategies, denial has been studied in its relationship to the outcome of disease. The majority of these studies (Grassi, Rosti, Lasalvia & Marangolo 1993; Schetter, Feinstein, Taylor & Falke 1992), agree that denial and various forms of repression are associated with generally unfavourable outcomes in cancer, such as faster disease progression, heightened emotional distress, and shorter length of survival. Other researchers, (Manuel, Roth, Keefe & Brantley, 1987; Felton & Revenson 1984; Derogatis, Abeloff & Melisaratos, 1979; Achterberg, Matthews & Simonton, 1977; Silverfarb & Greer, 1982), also found that responses to cancer that are assertive, self-reliant, information-seeking, openly expressive, confrontational, and even hostile are related to favourable outcomes.

One of the most well known researchers and authors on death and dying is Kubler-Ross (1995, 1997). She found that many patients go through different stages before eventual death. These stages are: (a) Denial and isolation (b) Anger (c) Bargaining (d) Depression (e) Acceptance. She warned, however, that one should not see these stages as a rigid one-way process but rather use them as guidelines to understand patient behaviour. She saw denial as the first stage because this is where the patient would say: *"No, this is not happening to me"*. She described it as a temporary

defence and said that the patient should be allowed to keep this defence as long as it was practically possible and needed to alleviate anxiety.

Schetter, Feinstein, Taylor and Falke (1992) found that coping through social support, focusing on the positive, and distancing was associated with less emotional distress, whereas using cognitive and behavioural escape-avoidance was associated with more emotional distress.

In contrast to the above-mentioned studies, Silverfarb and Greer (1982) suggested that denial might be adaptive in the early stages of cancer and Greer and Pettingale (1979) associated denial with favourable prognostic outcome.

In these studies of denial, there was a tendency, to view it as a static quality, which was measured only once. This research method did not take into account that denial functioned as a cognitive act and varied from moment to moment with the ebb and flow of negative emotion. Lazarus (1966) also emphasised that its operation might depend on situational factors. He stressed that, denial, as a theoretical concept in the study of patients' coping with having cancer, had to be defined in terms of "what" it was that patients denied and to what extent. This could vary from patient to patient and over different time intervals. Contrary to initial thinking, denial might be useful for adaptation under certain definable circumstances. According to Wool (1988) in the area of cancer, the act of denial could result in unconscious negation of symptoms of illness and cause a disruption of the help-seeking response. On the other hand, denial is, described as neither good nor bad in itself. What is seen as important to the oncology clinician is the way in which it may assist or impede an individual's adjustment to cancer. Moorey and Greer (1989) also stated that one should not automatically challenge denial during therapy, because it may be an adaptive way of coping.

When dealing with denial one should distinguish its various forms. One may deny facts, the true meaning of information and/or its likely future consequences, or one's emotional state. Lipowski (1970) confirmed that evaluation of denial must always include a consideration of what is denied, in what situation and by whom.

Findings by Feifel, Strack and Nagy (1987) supported the theory that conceptualised coping behaviour in dealing with life-threat as being shaped more by situational context than by personal style. Their results indicated that life-threatened patients used confrontation significantly more than did non-life-threatened patients in dealing with their illness.

Lipowski (1970) also confirmed the importance of the situational context in which denial should be interpreted. He viewed denial of illness or passive surrender to it as possibly adaptive during the acute phase of a severe illness, but as maladaptive in its later stages, when recognition of facts and active coping would be more appropriate. Morris, Blake and Buckley (1985) also confirmed that denial might at least be pragmatic adjustment in situations where little or nothing can be done instrumentally.

Lazarus and Folkman (1984) had an operational view towards the study of denial that takes situational factors into account. He pointed out that the meaning of denial posed a methodological problem because it is usually described as the rejection of reality. He offered the following principles for the specification of the conditions under which denial and denial-like forms of coping might have favourable or negative outcomes.

- (i) When there is nothing constructive people can do to overcome a harm or threat, that is, when there is no direct action that is relevant, denial and denial-like processes contain the potential for alleviating distress without altering functioning or producing additional harm.



- (ii) Denial and denial-like processes may be adaptive with respect to facets of the situation, but not the whole. Patients with diabetes can deny the seriousness of the situation as long as they also continue to give vigilant attention to diet, activity level, and insulin. The distinction between denial of fact and denial of implication is also relevant here. For example, it is probably more dangerous to deny that one has cancer than to deny that the diagnosis implies a death sentence. Denial of implication may be more akin to illusion, positive thinking, or hopefulness, which all of us experience occasionally. The capacity for these mechanisms may be a valuable psychological resource, rather than a distortion of reality.
- (iii) In chronically uncontrollable (and unchangeable) situations, denial may be the strategy that effectively reduces both arousal and concomitant processing of information from the environment.
- (iv) The timing of denial and denial-like forms of coping may be of major significance. Denial may be less damaging and more effective in the early stages of a crisis, such as sudden illness, incapacitation, or loss of a loved one, when the situation cannot yet be faced in its entirety, than in later stages (Lazarus & Folkman, 1984).

By using denial and denial-like processes Lazarus successfully illustrated that: (a) no strategy should be labelled as inherently good or bad; (b) the context must be taken into account in the judgement of coping; and (c) principles must be developed with which to judge whether a particular coping process suits both personal and situational aspects of the transaction. This is the approach that seems to be the most useful for the purposes of psychological research and should be used not only for denial, but should also be considered for coping.

#### 4.4 Information seeking versus information avoiding.

Personal experience and literature indicate that some cancer patients will actively seek every piece of information they can find about the disease in order to understand it better and to cope more effectively. On the other hand, there are those who avoid knowing too much and “leave it up to the doctors”. This behaviour would probably be relevant as additional information on the way patients cope with cancer and may be used during therapy. For example, those who actively seek information could be provided with books that can be discussed during therapy. In this chapter, the theories addressing coping and information seeking behaviour are described.

There are contrasting theories about whom should show better adjustment to breast cancer, information-seekers or information-avoiders. Safety signal theory, preparatory-response theory and information-seeking theory predict better adjustment for the information-seekers, because information allows one to discriminate the safe from the unsafe, to make the appropriate preparatory responses, and to reduce the inherent aversion to uncertainty. However, according to the blunting hypothesis, one cannot be upset by events to which one is not attending. Zemore and Shepel (1987) hypothesised that since information-seekers were more likely to be attending to threatening events than information-avoiders, information-seekers should show more emotional upset than information-avoiders.

To test whether information-seekers showed better adjustment than information-avoiders Zemore and Shepel (1987) did a study on 301 patients with breast cancer who had undergone a mastectomy between 1 and 26 months earlier. They administered the Social Adjustment Scale and a 47-item emotional adjustment scale, with four questions designed to measure information seeking.

Analysis showed a statistically significant correlation between information seeking and adjustment. Patients with breast cancer who scored high on information-seeking,

as indicated by their self-ratings of knowledge of breast cancer, amount read, and number of people with whom they talked to about breast cancer, also scored high on social adjustment and emotional adjustment. These findings are consistent with the safety signal, preparatory -response, and information-seeking theories, and inconsistent with the blunting hypothesis.

Hopkins (1986) developed an Information Preference Questionnaire (IPQ). In the process of developing this scale, which is an instrument to measure information seeking, 58 subjects were interviewed about their information-seeking practices. They were asked to complete the IPQ and two standardised instruments selected to measure how well the patient was adapting to the chemotherapy treatment experience. Information seeking was found to be negatively related with subjects' age and the severity of disease. No significant relationships were identified between information seeking and the adaptational outcome measures of mood states and level of functioning.

From a practical standpoint, the data from these studies suggest that a two-pronged approach should be followed to information delivery in medical contexts. Miller, Combs and Stoddard (1989) suggested that for high monitors/low blunters, voluminous preparatory and sensory information should be made available, with an opportunity to express emotion and a focus on explicit reassurances about the external sources of competence available. Conversely, for low monitors/high blunters, more minimal procedural information should be made available, with an emphasis on the patient as an important self-resource in the situation.

#### **4.5 Personality and behavioural factors**

One would assume that a person's basic personality structure have an influence on the way that person will cope with a chronic disease such as cancer. The theories

that attempted to explain coping behaviour from this perspective are called the state/trait theories.

The state/trait approach to coping includes a description of personality factors as traits that have an influence on development of and prognosis of cancer. These theories attempt not only to explain coping with cancer, but also to find a correlation between certain personality types and the development of cancer. They also attempted to show differences in coping with cancer between certain personality types.

The idea that certain personality types might be more prone to develop cancer is not new. In an introduction to their own work on this subject, Greer and Watson (1985) referred to a second century Roman physician, Claudius Galenus, who said that melancholic women were more prone to develop cancer than those of sanguine temperament.

Although the description of personality types had changed, the theory still exists that psychological factors contribute in some individuals, through interactions with biological homeostatic mechanisms, to the promotion of certain cancers. Fox, (1981), Bovbjerg (1991) and Baltrush, Stangel and Titze, (1991) wrote excellent reviews on those studies that dealt with psychological factors, the immune system and cancer.

Eysenck (1985) was one of the founders of the trait theories of personality. By applying factor analysis he identified common patterns which he defined as personality traits. In his work with cancer patients Eysenck (1988) identified two major personality traits which appear to characterise the cancer-prone personality. The first trait is a helpless/hopeless reaction to stress, involving a failure to cope with a stressful situation, and secondly a rational non-emotional, repressed reaction to life events, that would normally produce strong reactions, such as fear or anger.

Greer and Morris (1975) found an association between the diagnosis of cancer and a behaviour pattern of extreme suppression of anger throughout adult life. This correlation reached statistical significance only in women under 50. Similar findings were obtained in a second group of women with breast tumours where they reported a significant association between a diagnosis of breast cancer and an abnormal pattern of emotional behaviour, particularly the extreme suppression of anger.

Three other investigations done by Jansen and Muenz (1984) and Wirsching M, Stierlin, Hoffman, Weber and Wirsching, (1982) and Morris (1980) found expression of anger to be significantly less frequent among breast cancer patients than among controls.

Results of a prospective study done by Scherg and Hum (1987) showed that breast cancer patients, when compared with women with benign breast disease, showed less anxiety and a less pronounced Type A behaviour. They were described as more committed to social and religious norms and data on the Social Desirability scale indicated that cancer patients put off their own wishes in favour of a more socially desirable behaviour.

Grassi and Molinari (1988) investigated the relationship between suppression of negative feelings and psychological reaction to cancer. A series of breast cancer patients were studied preoperatively (n=35), a week after mastectomy (n=32) and six months later (n=12). Six months after surgery, hostility (SQ Hostility scale), inability to express feelings to others and a tendency to perceive the somatic effects of the illness, were associated with emotional repression.

Cheang and Cooper (1985) also confirmed this trait in cancer patients of not expressing feelings. They claimed that the concealment of feelings is the one distinguishing feature of breast cancer patients.

Jensen (1987) studied 52 women with a history of breast carcinoma and 34 healthy women prospectively. A multiple regression analysis which controlled for disease stage at original diagnosis, age, total length of disease course, haematological factors and blood chemistries at study onset, showed neoplastic spread to be associated with a repressive personality style, reduced expression of negative affect, helplessness-hopelessness, chronic stress, and comforting daydreaming. They suggested that further research should be done to examine the role of psychological functioning upon health-relevant behaviours that might blunt the benefits of health care.

The description of psychological factors which might have an influence on the initiation and development of cancer led to a theory of a pattern of psychological attributes called "Type C" behaviour.

#### **4.6 Type C" behaviour**

Morris (1980) stated that suppression of emotional responses, particularly anger, appears to be central to the "Type C" behaviour pattern. Greer et al. (1985) tested the importance of this behaviour pattern as a prognostic indicator, in patients with malignant melanoma, and found it to be significantly associated with thicker and more invasive tumours in the under 55 age group. "Type C", behaviour was also associated, in this study, with a "defensive" response to stress, defined as being "high on both self-reported social desirability and anxiety". They suggested that it was suppression of behavioural responses rather than repression that was important. Subjects were aware of their negative emotions, as evidenced in self-reports, but suppressed behavioural reactions.

According to Weinberger, Swartz and Davidson (1979) breast cancer patients tend to control their emotions and adopt a rational, non-emotional approach to life. Their data

validated the tendency towards emotional control: i.e. the breast cancer group was rated as less expressive than the control group.

Pettingale, Burgess and Greer (1988) described the effect of this type of psychological response as having an influence on prognosis, independent of other known prognostic variables.

Cooper and Farragher (1992) did a prospective study of 2163 women attending a breast-screening clinic, or attending a routine medical check-up. They found a statistically significant relationship between the methods used to cope with stressful situations and breast disease. The group of women who fared "best" in this study (i.e. had a diagnosis of either no disease, or benign disease) used more coping strategies than their counterparts. Their strategies were positive in the sense that they either sought external social support or increased their internal strengths by improving their perceived locus of control.

Renneker, (1981) who did psychotherapy with cancer patients, emphasised the "pathological niceness syndrome" of cancer patients. They appeared to be compliant, submissive, passive, selfless and anxious. They tended to please in order to avoid being disliked. Cancer patients viewed themselves as being externally controlled. They perceived their illness as an anonymous blow and showed a low sense of control and marked helplessness regarding their ability to influence their own lives and health.

#### **4.7 Critique of fixed coping styles**

In view of the more flexible approach towards psychological reaction to stress as described in Lazarus's (1984) theory, it seems imprecise to describe behaviour into categories such as "Type A" or "Type C" behaviour. Syme (1989) described the category approach as an over-simplification of terms, that limits research within that

framework with the result that the multifactorial nature of coping behaviour is lost. Hilton (1989) underlined the importance of multifactorial research in her correlational study of the relationship between commitments, uncertainty about the cancer situation, threat of recurrence, and control of the cancer situation and a set of coping strategies. She stressed that the real world is complex, with many influencing variables, and it seemed that a broad perspective might better account for major variables in coping with breast cancer.

A review by Levenson and Bemis (1991) of the literature on cancer and its potential connections to affective states, coping/defensive styles and personality traits, behaviours, and stressful life events showed that much of the research was flawed by poor study design. While some psychological factors can be associated with cancer onset and progression, no direct links have been established. In his review of the current theory of psychogenic effects on cancer incidence and prognosis, Fox (1983) concluded that there was not enough evidence to support the theory that psychological factors had an influence on cancer incidence. Almost ten years later, Mulder, Pompe, Spiegel, Antoni and Vries (1992) also came to the same conclusion in their review of the influence of psychosocial factors on the course of breast cancer.

Persky, Kempthorne-Rawson and Shekelle (1987) undertook a prospective 20 year follow-up study done of 2018 middle aged men using the Minnesota Multiphasic Personality Inventory (MMPI) and the Cattell 16 Personality Factor Inventory (16PF). The data did not support the hypothesis that psychological repression was associated with the risk of cancer. The importance of this study is that when a prospective study is done on a big group, the trait theory does not always seem to hold.

Further evidence that psychological repression might not have an influence on the initiation of cancer, came from a study of S. Kreitler, Chaitnik and H. Kreitler (1993).



They examined levels of repression in three groups of women pre- and post surgery for breast cancer. The three groups were healthy women (n=40), those whose biopsy showed they had breast cancer (n=32) and women who underwent surgery unrelated to breast cancer (n=26). The results of their study of these 98 women indicated that repression could be a response to the threat posed by a cancer diagnosis and is a means for keeping anxiety at a tolerable level, rather than a personality trait of cancer patients.

In considering a chronic stressor such as illness, it is also possible that some individuals with long-standing disease may not use any particular style of coping. Newman, Fitzpatrick, Lamb and Shipley (1990) warned that attempts to force the data to place subjects onto dimensions such as emotion focused or problem focused coping styles, might lead to a deceptive picture of individuals' overall coping strategies. Jarrett, Ramirez, Richards and Weinman (1992) who found that the majority of patients use a wide repertoire of coping responses, confirmed this view.

It is also difficult to conceptualise how two such contradictory coping strategies as "fighting spirit" and "denial" are described as strategies resulting in longer survival. A fighting spirit strategy, requires an individual to accept the fact that she has cancer and "fight" it, while denial means not accepting the real situation. Moorey and Greer (1989) dealt with the complexity of denial and its implications in terms of coping with cancer, by stating that denial should not automatically be challenged because it might be an adaptive way of coping. It should, however, be questioned during therapy in certain situations. For example, if denial prevents the patient from undergoing treatment, if denial causes communication barriers with the spouse or when it is not effective as a coping strategy and anxiety and depression may occur. In the application of psychological therapy as adjuvant treatment for patients with cancer, Moorey and Greer (1989) moved away from the rigid approach towards coping strategies, towards a more flexible approach which suits the needs of the

individual patient and enable patients and spouses to deal in more effective ways with the threat of cancer.

Meyerowitz (1983) found that denial was the variable most strongly associated with post-mastectomy distress. Denial was more important in explaining distress than the availability of social support, age, or time since operation. Data from a study of Carver, Pozo and Harris (1991) also contradicted the finding that denial may be adaptive. They found, in their one year prospective study of 59 breast cancer patients that acceptance predicted less distress and denial predicted more.

The fixed theories described in the literature review do not accommodate for a more flexible approach towards coping where an individual copes with a situation according to the requirements of that situation at a specific time. The same breast cancer patient may deny feelings of being tired while at work, but may well spend much more time in bed to enable her to cope with her illness. There seems to be evidence of both variability and stability in coping behaviour and research designs should accommodate this.

The psychoanalytic approach that many of these personality theories adopt to illustrate how some individuals are predestined to develop cancer, does not explain how many people with similar unhappy childhood experiences and similar coping strategies do not develop cancer. Somerfield (1992) mentioned the pragmatic advantage of adopting a state, rather than trait, approach to coping. In terms of intervention, it may be easier to change a person's way of coping within a specific situation (what they do) rather than change a coping trait (the way they are). Adjuvant psychological treatment seemed to prove this point, as is illustrated in the following study.

Spiegel's (1993) pioneering study, demonstrated with his pioneering study that women with breast cancer who received adjuvant psychological and social support in

group therapy sessions, suffered less from depression and anxiety and reported that they experienced less pain than a control group of breast cancer patients. Four years after commencement of the study, he found that the average survival time for the control group was 18.9 months and 36.6 months for the experimental group. This meant that, from the time that they entered the study, the women in the experimental group lived twice as long as those in the control group. This work gave further evidence that was confirmed by Leszcz and Goodwin, (1998), that the adoption of a pragmatic approach towards the enhancement of a patient's coping skills may well work towards a better quality of life and possibly a longer life than the use of a theoretical framework where patients coping strategies are described as personality traits which may be difficult to change.

Heim, Augustiny, Schaffner and Valach (1993) came to the conclusion, after their five year prospective study on coping with breast cancer, that there was evidence of constant dimensions as well as variability in coping. It seems that coping is an elusive concept that needs further refinement through long-term follow-up procedures and repeated measures. Current group psychotherapy with patients with cancer, attempt to enhance coping by finding meaning in the experience of having a chronic illness (Greenstein & Breitbart, 2000).

In spite of methodological differences, Glanz and Lerman (1992) found in their review of recent literature on the psychosocial impact of breast cancer, that they agreed that as many as one-quarter of women with breast cancer suffered psychological morbidity. Hopwood, Howell and Maguire (1991) found that one third of their group of two hundred and twenty-two women suffered from affective disorder. Plumb and Holland (1977) found that about a fourth of 97 cancer patients were moderately or severely depressed. Bukberg, Penman and Holland (1984) recorded that 42 percent of 62 oncology patients met criteria for non-bipolar major depression, using the DSM-

III diagnostic criteria. Hopwood et al. (1991) reported that 39 per cent of 75 women who underwent mastectomies had serious anxiety, depression, or sexual difficulties.

If the diagnosis of an initial breast cancer is so devastating to many patients, it seemed important to study the psychological impact of the news of recurrence. Greenberg (1992) stated that the diagnosis of serious and treatable disease was essential to competent medical care and to leave undiagnosed and untreated depressive disorder in cancer patients was "unconscionable". In spite of the fact that it seems so obvious that patients must be devastated by the news of recurrence, very little has been done to explore their reactions so that behavioural interventions to improve psychosocial adjustment can be developed. Hall and Fallowfield (1995) found, in their study on psychological morbidity of patients with breast cancer, that of the 38 women with recurrence, only 8 were offered some form of support by a specialist nurse or hospice nurse.

In studying responses to a diagnosis of cancer, a number of criteria need to be taken into account, including the extent to which the overall pattern of the person's psychological responses enables him/her to:

- (i) regulate or avoid persistent painful emotion;
- (ii) co-operate with medical recommendations;
- (iii) achieve a position which facilitates the optimum adjustment of close others to his/her predicament; and
- (iv) maintain cherished values.

## 4.8 A process approach towards coping

It seems clear from the above critique, that the explanation of the psychological experience of cancer in terms of a fixed trait personality theory, does not leave enough room for satisfactory explanation of the complexity of the individual experience of cancer. A theory, which accommodates the ever-changing nature of human experience, seemed to be more appropriate for the type of study intended here. The coping theory of Lazarus (1991) seems applicable to the description of the multifaceted aspects of the psychological experience of cancer. Although his theory is mainly a coping theory, it also encompasses the wider perspective of the total psychological experience of the disease and it emphasises the relational interactions that take place.

Lazarus (1991) described coping as constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. In line with this description, Lipowski (1970) defines the coping of a patient with his illness, as all cognitive and motor activities which a sick person employs to preserve his bodily and psychic integrity, to recover reversibly impaired function and compensate to the limit for any irreversible impairment. He describes coping behaviour as a result of multiple factors reflecting a patient's specific disposition, as well as characteristics of his total situation during a given episode of illness and its different phases. The way in which the patient copes with his illness spells the difference between optimum recovery and psychological invalidism.

The conceptual framework for this study of the psychological impact of the knowledge of a recurrence of cancer and the way patients cope for one year after such a diagnosis, is derived from the coping theory of Lazarus (1984). It was a development in coping theory and research in which the hierarchical view of coping,

with its trait or style emphasis, was abandoned in favour of an approach that treated coping as a process. From a process perspective, coping changes over time and in accordance with the situational contexts in which it occurs.

Lazarus does not exclude the idea of traits totally. He proposed a combined intra- and inter-individual research design to allow the study of coping in both its state and trait aspects. State, according to Lazarus, represents instability (flux) or change. Trait represents stability or consistency across diverse conditions. If coping consistency over time and across encounters is emphasised, we are dealing with the trait concept; if we emphasise contextual influences and coping inconsistency over time and across encounters, we are dealing with the state concept or process. Lazarus described these as two sides of the same coin, and both sides are usually relevant. Confirmation of this argument of both variability and stability in coping behaviour over time and situation comes from a study by Heim, Augustiny, Schaffner and Valach (1993). They found in their study of 74 breast cancer patients followed for 3-5 years at 3-6 monthly intervals, that three dimensions of coping appeared to be constant, namely, support and acceptance; denial; and diversion by thought and action. They found evidence of variability in the potential range of coping modes used. This variability in coping was further increased when coping was assessed over predefined stages of illness, that were described as different clinical situations.

The purpose of this study is to determine how different individuals experience the stressful situation of having a recurrence. Coping is studied as the process through which the patient manages the emotional demands that recurrence places on the person and her relationship with her husband.

Lazarus's (1991) process approach to coping has three main features, which have all been taken into account in the planning of this study.

Firstly, observations and assessment are concerned with what the person actually thinks or does, in contrast with what the person usually would do, or should do, which is the concern of the trait approach. In this study, the assessments cover the actual behaviour, thoughts and emotions of the patient and her family.

Secondly, what the person actually thinks or does is examined within a specific context. Coping thoughts and actions are always directed towards particular conditions. To understand coping, and to evaluate it, we need to know with what the person is coping. The more narrowly defined the context, the easier it is to link a particular coping thought or act within a contextual demand. This study covers coping behaviour of cancer patients with the diagnosis of breast cancer and recurrence.

Thirdly, a coping process entails change in coping thoughts and acts, as a stressful encounter unfolds. Coping is, thus, a shifting process in which a person must, at certain times, rely more heavily on one form of coping, say defensive strategies, and at other times on problem-solving strategies, as the status of the person-environment relationship changes. A study by Edgar, Rosenberg and Nowlis (1992) on coping with cancer during the first year after diagnosis showed that the emotional coping of patients improved over that time. Time itself leads to changes in coping behaviour. Folkman (1984) maintained their coping theory as a description of two processes: namely coping as appraisal and coping. These processes are mediated by stress and are now used to focus attention on an important aspect of coping.

As Lazarus points out, the importance of studying coping behaviour is to determine if some coping patterns are more serviceable than others in given types of people, for given types of psychological stress, at certain times, and under known conditions. The study of coping as a process is a new approach compared with studies on coping within the trait approach.

According to the process theory, both cognitive appraisal and coping are critical mediators in stressful encounters. The individual evaluates first whether anything is at stake in an encounter (primary appraisal). Then the individual evaluates whether anything can be done (coping responses) to overcome the threat and prevent harm (secondary appraisal). Primary and secondary appraisals are influenced by personal and environmental variables. Personal variables include values, commitments, and beliefs; environmental variables include situational demands, constraints, and social resources. If an encounter is perceived to be threatening, coping responses are activated. The first function of coping is to control the problem causing the distress, and the second function is to minimise emotional distress.

As the personal and environmental variables of Lazarus and Folkman's theory suggest, every person interprets and appraises the recurrence in a slightly different manner, because of previous experiences and support available at the time of recurrence. In this study coping is a psychosocial issue, which refers to an interaction between intrapersonal and interpersonal events. Adjustment concerns the response to the environment in an adaptive manner. Dobkin and Morrow (1986) stated that psychosocial adjustment in oncology referred to the way in which the experience of having cancer is handled by the individual.

Folkman (1984) summarised their coping theory as a description of two processes, namely cognitive appraisal and coping. These processes are mediators of stress and stress-related adaptational outcomes. An important aspect of coping within this theory is control. In the context of this theory control can be approached in two ways: as a generalised belief of an individual concerning the extent to which he or she can control outcomes of importance and as a situational appraisal of the possibilities for control in a specific stressful encounter.



According to Folkman (1984) process theory described a stage of primary appraisal where the individual appraises the harm, loss, threat or challenge involved in the stressful situation. If the person interprets the situation as threatening or harmful, emotions such as anger, fear and resentment usually occur. When the situation is interpreted as a challenge emotions are usually pleasurable such as eagerness and excitement are involved. Folkman also pointed out that generalised beliefs about control, which concern the extent to which individuals assume they can control outcomes of importance, influence primary appraisal. Rotter (1966) said that generalised control expectancies have their greatest influence when a situation is ambiguous or novel.

Secondary appraisal comprises the evaluation of coping resources and options. Folkman (1984) described secondary appraisal as addressing the question, "What can I do?" and it becomes critical when there is a primary appraisal of harm, loss, threat, or challenge. Situational appraisals of control are part of secondary appraisal and refer to one's belief about the possibilities for control in a specific encounter.

#### **4.9 Conclusion**

This chapter describes theories that may enhance understanding of how patients may experience a chronic disease such as cancer. It discusses previous studies done within the frameworks of those theories. It seems as though most of those studies were done using a more positivistic approach, than suits the medical model. The quantitative phase of this study could be compared to those studies, but it employs a different approach to the psychological experience of breast cancer.

In order to obtain a different point of view on the same phenomenon, a more qualitative approach is followed to examine the experience of persons with breast

cancer. The qualitative approach leans heavily on interactional theory, which is discussed in the next chapter.

## INTERACTIONAL THEORY

### 5.1 Introduction

The aim of the study is to take a broad integrative view of the experience of living with cancer. This means that to do this as properly as possible on how patients experience living with cancer, no one theory or just one method could be followed. To this end, quantitative as well as qualitative methodological approaches were used. The qualitative approach is explained in the example chapter and in the next chapter. The discussion in this chapter shows the view of the theory upon which the qualitative research was based and the reasons for the inclusion of therapeutic interviews as method of inquiry in this study.

In order to understand the living with cancer for an individual starting at the beginning of the experience of having cancer, one is forced to remain aware of different psychological theories as well as the nature of the disease. Different psychological theories such as social learning theory, coping theories, theories of locus of control and self-efficacy, and all disease applicable and are discussed in several chapters. Psychological theories however, deal with intellectual ways of thinking about man and life itself. When it comes to people's experience of illness and specifically a disease such as cancer, specific psychological theories need to be addressed if research in the field of psychoncology (Guex, 1994) is to be undertaken.

Bandura (1966, 1977) pointed out that the relative influences exerted by interdependent factors, differ in various settings and for different behaviours. He showed that there are