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Counseling Intervention Methods for the Adult with Advanced Cancer: A Review of the Literature

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COUNSELING INTERVENTION METHODS FOR THE ADULT WITH
ADVANCED CANCER: A REVIEW OF THE LITERATURE

by

Rita Catherine Rogers

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University Chicago in Partial Fulfillment
of the Requirements for the Degree of
Master of Arts

May

1991

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Dedication to

Geraldine Swanner Hensel (1938-1984) colleague, friend and fellow Loyola alumnae, who through her yearning for people to care, so exemplified the need for cancer counseling--she taught me how to hope. And to all of my other cancer patients who, without anything more to lose, welcomed me into their world--they have taught me how to live.

Richard P. Issel, Ph.D. (1938-1990), whose caring friendship and disciplined curiosity unknowingly encouraged me to pursue a role with cancer patients.

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Finally my sincere thanks to Valerie Collier. Her friendship and expertise have been essential in the completion of this project.

VITA

The author, Rita Catherine Rogers, is the daughter of Fred Rogers and Margaret (Tufts) Rogers. She was born July 9, 1940, in Davenport, Iowa.

Her elementary and secondary education was obtained through the Catholic school system in Rock Island, Illinois where she graduated from Alleman High School in 1958.

In 1961, she graduated from St. Anthony's Hospital School of Nursing, and in 1968, she obtained a Bachelor of Science in Nursing degree from Loyola University of Chicago. While attending Loyola University, she worked in staff positions in the Emergency Room at St. Francis Hospital, Evanston, Illinois and in psychiatry at the Illinois State Psychiatric Institute at Chicago with roles in Community Psychiatry and Schizophrenic Research.

She assumed a faculty position at St. Anne's Hospital School of Nursing from 1970 to 1975. During this time she also increased her technical skills in emergency room nursing and became certified in Trauma Nursing for the State of Illinois in 1974. From 1975 to 1980, she taught in both Nursing Inservice Departments and in Adult Continuing Education at a Community College.

Currently, she works in a Hematology/Oncology unit in Chicago where she cares for advanced stage adult cancer patients.

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CHAPTER I

INTRODUCTION

Psychosocial intervention with cancer victims has taken on new meaning and enthusiasm within the past few years. While much time, effort and finances have been spent on research concerning both the newly diagnosed and the dying patient, fewer studies have been done concerning the person with advanced disease who struggles with the task of daily living. Those with advanced cancer are in a chronic living-dying phase of life marked by multiple crisis of remissions and exacerbations. Past coping patterns may not be applicable to this newer experienced phenomenon ending in possible death.

Much of the early work done by LeShan (1966), Kissen (1963), and Green (1954) dealt with various life events and personality characteristics which strongly suggested a relationship to cancer development. These discoveries were abhorred by the medical community and the general public. Even with the unveiling of the coronary-prone Type A behaviors by Friedman and Rosenman (1974), the idea that certain behavior patterns and life styles could contribute to cancer development is still generally unacceptable except

by a small segment of the population. The locus of control is generally thought to be a matter of fate.

Many of these early studies were abandoned during the late 60's and early 70's when Kubler-Ross changed the focus with her stage theory. She took the nation by surprise when, by her example, she gave permission to talk openly about the dying trajectory with the client. She took research out of the statistical realm and humanized it at the bedside. While her stage theory is currently challenged by many, the involvement that has taken place from its introduction has resulted in increased care and concern that the cancer patient be accepted as a person, be granted the liberty to be involved in his care, learn new skills to reduce stress and modify certain behavior patterns. This has broadened the scope and possibilities for the use of mental health professionals in the care of those with partial health. With some of the latest medical therapies, an individual with advanced cancer can be in the progressed stage of disease for months before entering a terminal phase of terminal illness. Regardless of the more optimistic prognosis of patients with cancer, anticipatory grief and concern over an uncertain future shadow the person from the time of diagnosis. Therefore patients as well as their families may be in need of frequent emotional support.

Purpose

This study will endeavor to provide a review of the

literature regarding therapeutic intervention methods used in counseling adults in the advanced stages of cancer. The various methods will be compared and contrasted. Current psychosocial research projects and network resources will be identified. It is expected that the outcomes will alert the professional to the methods used in the psychological intervention of adults with a terminal cancer prognosis and to define areas for future research.

The Need

Investigation of the literature has indicated a lack of organization by those counseling cancer patients and those involved in quantitative and qualitative research projects. Much duplication currently exists. More integration is needed to facilitate the development of a more clearly defined oncology counselor role.

Chapter one will introduce the topic material, identify the purpose of the thesis, and review the content of each chapter. It will also identify for the reader the need for the investigation, provide necessary definitions and clarify limitations of the study.

Chapter two will contain sections of the review of the literature. It will proceed from a comparing and contrasting of oncotherapy/counseling with general psychotherapy and will generally document what counseling is expected to accomplish with this special set of clients. Some identifying elements needed in counselor preparation as

well as personal characteristics will be noted. A progression will be shown toward the area of the cancer prone personality which incorporates life stress events, locus of control and inheritance factors in cancer behavior and how this type of personality can best be helped to cope with their advanced disease. Counseling interventions will flow from the preceding material and deal with the two major philosophies of helping. In Chapter three conventional as well as non-conventional methods of intervention will be researched.

Chapter four will show conclusions, implications, suggested recommendations and identify needs for further research.

In addition, tables will be provided to illustrate the various research projects conducted on this topic of counseling cancer patients.

Limitations

This study is limited by its concern of the adult physically ill patient and is broadened by the lack of phases of adulthood frequently used by other researchers. The concern is with those adults both male and female with advanced cancer versus newly diagnosed or curable clients. The individual person is the major focus, while the role of the individual within a family unit is dealt with to a lesser degree. The family as a separate responder to the cancer victim is not dealt with at all.

The majority of the material reviewed is restricted to citations from studies conducted in the United States. Data collected is for the period from 1970 to 1990. The study is not limited by site of disease location but rather is inclusive of whatever studies concerning counseling could be extrapolated from the literature.

As a prelude to the various counseling interventions, this paper includes preparation needed by the counselor for the role of oncotherapist. Conventional as well as non-conventional methods of intervention are discussed as they related to ways of coping for the person with Type C behavior characteristics.

Definitions

Advanced cancer - the extension of cancer cells beyond the immediate region of the primary tumor. Examples: tumor metastasis from the testes to the spinal cord (CNS); from the breast to the ovaries.

Chronic illness - defined in 1956 by the Commission on Chronic Illness as any impairment or deviation from normal that has one or more of the following characteristics: 1) is permanent; 2) leaves residual disability; 3) is caused by non-reversible pathological alterations; 4) may be expected to require a long period of observation, supervision or care.

Hospice - a multidisciplinary approach for the care of the terminally ill incorporating social, psychological,

medical and spiritual services, usually with family involvement. The goal is to make the person as physically and emotionally comfortable as possible with special emphasis on control of pain.

Endorphins - a morphine-like substance found in the brain, spinal cord and gut. Both stress and pain are known to activate release of this substance. A correlation exists between low endorphin levels and low serotonin levels seen in endogenous depression and migraine headaches.

Psychological autopsy - an instrument by Weisman/Worden for postmortem assessment of how a person progressed psychologically until death.

Life-Review - a naturally occurring mental process characterized by the progressive return to consciousness of past experiences and conflicts to be surveyed and reintegrated.

Trajectory - the pattern of decline in the process of dying and characterized by various levels of awareness.

Type A personality - behavior pattern includes: hurried speech, open impatience, chronic sense of time urgency, vague guilt during periods of relaxation, overconcern with getting things worth having with no time to become the things worth being; as well as characteristic nervous gestures - tics, clenched fist, and grinding teeth. In addition they possess skills for emotional catharsis.

Type B personality - behavior pattern includes:

complete freedom from all Type A traits, no sense of time urgency, no free floating hostility, no felt need to discuss achievements unless the situation demands it, able to enjoy play and relaxation without need to exhibit superiority. Also, an ability to relax without guilt and to work without agitation.

Type C personality - a controversial cancer prone personality with many of the characteristics of a Type A person with the exception of lacking the skills for emotional catharsis.

Methods/Procedure

Materials

A comprehensive search was conducted for all topics relative to advanced cancer/psychotherapy/counseling dating back to 1970 through 1990. In the beginning the tables of contents were reviewed of those journals most likely to contain the needed data and included Social Work in Health Care, Journal of Psychosocial Oncology, Journal of Behavioral Medicine, Oncology Nursing Forum and Cancer. The references at the end of the articles led to an expansion of data and aided in consolidating the design. Several masters theses and doctoral dissertations were read for content as well as format, language and style. Computer searches were done at various stages of writing and included Psychological Abstracts, Cancerlit, and Medline. A manual search through Dissertation Abstracts International was done for the years

1970-1989 using the key word index of patients/psychology/cancer. The "Medical and Health Care Books and Serials In Print - 1987, updated the resources as did personal subscriptions to medical and nursing journals. In addition, attendance at numerous workshops relating to the psychosocial care of cancer patients provided introductions and discussions with such major researchers in the field of oncotherapy and self care as Lawrence LeShan, Ira Progoff, David Bresler and Bernard Segal. Telephone contact with Dr. William Worden at Boston's Massachusetts General Hospital led to a discussion and purchase of a copy of the longitudinal Omega Project. Pharmaceutical companies generously provided audiotapes on topics that include "Conversation After Mastectomy" and "Depression and Cancer." Tape sets were also purchased and experienced on Relaxation/Hypnosis/Imagery by both David Bresler and The Simontons, "Helping Patients Cope" by Drs. Worden/Sobel; and "Personal Enrichment Through Imagery" by Arnold Lazarus. Two medical school libraries, three university libraries, and three community hospital libraries were frequented. Lastly, in the course of writing this thesis, an unexpected personal experience as a patient on an oncology unit had a positive note in that it deepened a perspective of the needs/concerns/tasks that cancer patients experience. And it exemplified where desires for counseling and need of support exist. "When God closes one door, He opens another"

took on a more profound meaning.

Procedure

References were limited to American sources, adults versus children and to those studies focused on psychosocial intervention in advanced cancer by definition of advanced cancer. Hospice and the terminal phase of the terminal stage were omitted. This distinction between advanced/terminal and terminal/terminal was needed to select the growing number of people who, due to advanced cancer technology survive with metastasis and or the development of second cancers for longer time spans before reaching the hospice stage of dying. They are the "limbo people"-- neither well nor finalizing death, and who struggle daily to survive.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

Early in the 1900's, counselors tended to be employed in school and community settings and were occupied with a wide variety of human concerns. This generalist role has evolved over the years, and today more specialization prevails with focus being directly to specific populations with unique needs. Harper (1985) has studied a progressive movement in the counseling profession that has reached greater emphasis now in the areas of health maintenance and prevention of illness. He sites Gazda's (1984) research update of groups which focuses among other things on counseling of hospitalized patients concerning death/dying, values clarification, sexual adjustment and other issues of illness.

The initial and terminal stages of living with cancer have received great attention in previous research studies. The focus of this thesis is a concern with the psychological intervention of those individuals who are struggling in the living/dying phase of advanced stages of cancer. A select review of the literature from 1970 to the present (1990) will trace what has been done to help this select group of

ill people live fulfilled lives until death. The main concern is not with the dying process, though this is a part of advanced illness, but rather with how a person can be helped to live until death arrives.

Certain facts remain concerning cancer that need to be considered when thinking in terms of the possible need for further emotional interventions. Despite decades of funding and intense research, medical science has not yet found a way to eradicate this disease. Cancer remains the second leading cause of death in the United States and is the most feared disease of the 20th century. Many people regard cancer and death as synonymous.

Each January, the American Cancer Society provides statistics for the estimated incidence and deaths by site and sex for the year ahead (see Appendix A). In 1983 it was estimated that one in four Americans will develop cancer sometime during their life. Latest information on cancer research indicates that one in three children born in 1986 will at some time develop cancer.

Three million Americans are alive today with a history of this disease. Two million of these people were diagnosed five or more years ago. While some of these can be considered cured, others still have evidence of the disease or are at risk for recurrence. The recurrence of cancer can pose as great an emotional threat if not a greater threat, than the initial diagnosis (Abrams, 1979; Cantor, 1978,

Chekryn, 1984; Clark, 1976; Parsons, 1977; Scott, 1983).

New and more aggressive cancer treatments are keeping patients alive longer and substantially altering the life-death trajectory. Many patients experience multiple remissions between the time of diagnosis and death. Therefore, there may be multiple reprieves from death and the challenge of living once again (Scott, 1983).

Because advanced cancer has taken on the characteristics of a chronic illness, it can be characterized by unpredictable trajectories, uncertain remissions, and recurrence at other sites. The course of the illness might be likened to a ride on a roller coaster, with its frightening peaks and valleys and short periods of coasting; however, the advanced cancer patient can never get off until stopped by death. This view is supported by Renneker in Goldberg (1981) when he states: "Adjusting to cancer is long term, ongoing and periodic. The problem is acutely, chronically there, so long as the cancer is, and periodically for years thereafter" (p. 136). Weisman (1976) asserted that as cancer spreads throughout the body, it spreads into social and emotional domains challenging life's values and disrupting families. He has identified coping, especially with the uncertainty of the disease, as being one of the major tasks faced by the patient and family. Statistics show that conflicts between patient and spouse, patient and relatives as well as co-workers occurs 91% of

the time.

It is a mistake to think that all cancer patients face similar problems or that they are equally distressed at the same time. There are transitions which merit recognition as indicating separate psychosocial phases in the life of the cancer patient (Weisman, 1976, p. 162).

Weisman cautions his readers that -

There are no typical cancer patients, only people with cancer.... Understanding the cancer patient is based on an assumption that another person can be understood and empathized with, even though he or she undergoes an experience that is difficult to share and often evoke a measure of aversion. Consequently, assessment of cancer patients requires vigorous, uncompromising, persistent, and candid self-monitoring on the part of caregivers? (p. 162).

Persons with cancer do not live in a vacuum with cancer being their only problem. There may still be a need to maintain employment, do house work, deal with their teenagers' adversities, pay bills, and have enough energy left to be a good spouse. Cancer patients' homes flood during storms and they may be involved in fires, divorces, car accidents and other stressful events concurrent to their disease. Their cancer is another occurrence in their lives and is not the only stressful event that they have to deal with on a day to day basis. It does not occur in a vacuum. The need for counseling may exist in any of these areas on a personal or interpersonal level.

The advent of counseling cancer patients began long before Kubler-Ross wrote her first book in 1969. However, the pioneering work in the 1950's and 60's by Lawrence LeShan and others with cancer patients took on renewed

notoriety after the humanistic work by Kubler-Ross. Perhaps it was the timing of Dr. Ross' person to person non-authoritarian approach that made her work with cancer patients more acceptable. The 1960's were rebellious years and many were involved in the anti-establishment and highly criticized by her colleagues. She became recognized and accepted more by psychologists whose hard work with cancer patients had been rejected due to its qualitative vs. quantitative presentation. What they had been struggling with could not be scientifically proven to be of worth by their judges in the medial and scientific worlds. To have a psychiatrist from so profound an institution as the University of Chicago take a qualitative approach seemed to give more credibility to Dr. Ross' work. She spoke openly with cancer patients about their illness, feelings of dying and what helped and didn't help them. It was almost with a sigh of relief that at last a credible someone of the medical profession openly confronted the long neglected needs of cancer patients with something more than the pat on the head and empty promises. While Ross and her followers were scorned by the medical profession, the rest of the nation, with the help of the news media, seemed to hail her.

By her example and the guidelines she provided, a change in the course of events has occurred for those wishing to help cancer patients improve the quality of life through the counseling process. A more holistic approach to

the living/dying process has begun to evolve. A subjective view is that many in the medical profession have begun to recognize the person that co-exists with the disease, and that referrals for medical counseling are starting to be made with greater frequency out of concern for the person vs. criticism of the individual.

Because advanced stages of cancer may be with a person from several months for up to two-five years, there exists an opportunity to utilize a variety of psychotherapeutic treatment modalities. There will be periods of remissions and exacerbations. The methods and goals of any approach will depend upon the individual patient/client and that person's current life situation that requires intervention. One always begins where the client is.

It should be pointed out that there exist various levels of depth and commitment in meeting the psychotherapeutic needs of the advanced stage cancer patient. Selectivity of subjects based on various diseased organ sites, may limit the amount and kind of counseling provided some clients in research settings. The actual use of oncotherapists is limited at the present time, but is expected to grow rapidly in the next few years (Klagsbrun, 1983). Not all cancer patients require or want the assistance of a counselor; significant others may be able to meet their needs without further intervention (Worden & Weisman, 1980).

In their article, "Do Cancer Patients Really Want Counseling," Worden and Weisman (1980) screened patients to determine those more "at risk" for future psychosocial distress. When offered entrance into a counseling program, they found that those who rejected counseling did so based on a feeling of threat or considered the offer an omen of disaster. Those who refused tended to deny difficulties, minimized problems and in certain instances were truculent and suspicious. In contrast, those who accepted treatment, while just as much at risk, did not deny, but tended to feel more hopeless. They found that cancer patients are temporarily distressed and intervention may be short term. Questions that need to be asked are 1) which cancer patients are at risk for future psychosocial problems; and 2) what intervention would be most effective? Reasons that patients give for refusing or accepting counseling may indicate their attitude toward illness and its repercussions. Their study revealed that twice as many "at risk" patients decided to participate in the counseling process than those who refused. They felt that this indicated that those at risk recognized potential psychosocial consequences.

The following table is an illustration of how the counseling focus may vary in terms of content and length of commitment.

Table 1

Counseling Content and Length of Commitment

Short Term Commitment Clinical Employment / Symptoms	Long Term Commitment Counseling/ Psychotherapy / Psychoanalysis Thanatology
<ul style="list-style-type: none"> - Involves much teaching and information giving. - Goals of client and counselor are frequently achieved. 	<ul style="list-style-type: none"> - Involves more psychodynamics and examining interactional relationships. - Goals of client and counselor may/may not be achieved.

Dealing with employment and physical symptoms may be concurrent. Occupational concerns and how to cope in the work place are then replaced by how to deal with the progressively debilitating symptoms of the disease i.e., nausea, vomiting, pain, fatigue, and insomnia. Sometimes the impact of serious illness needs to be dealt with in parts. This segmentation may or may not involve denial of other needs. It has been stated by Peck (1972), Dansak (1978) and Hackett (1983), that denial may be what is most healthy at certain times on the life-death continuum.

Whatever kind or amount of psychotherapeutic intervention is conducted, it is almost always as an adjunct to other medical/surgical treatment regimes. At the present time, counseling interventions seem to be scattered and inconsistent as multiple disciplines assume the role of therapist.

It is necessary to preface any discussion of the various kinds of counseling/psychotherapy currently utilized with cancer patients, with some distinctions of how oncotherapy differs from other psychotherapy as well as preparation needed by the therapist for such a role.

Oncotherapy vs. Other Psychotherapy

It was Klagsbrun (1983) who first coined the term oncotherapist for those engaged in cancer psychotherapy. He, along with Schneidman (1978) and others believe strongly that the advanced cancer patients are unique to those with

other chronic illnesses. Schneidman suggests that the work done with the advanced cancer patient is both conceptually and qualitatively different than work done with those individuals not concerned with a limited life span; such work demands a different kind of involvement. He further suggests that there is a conceptual difference between ordinary psychotherapy and therapy with those in the living/dying stage of life as there is between psychotherapy and ordinary talk. He has outlined these differences as he views them in regard to content, level, meanings, abstractions and role (see Table 2).

The main point to be made was that when a clinical thanatologist (physician, psychologist, nurse, social worker, or any trained person) is working with a dying person, he or she is not just talking. This is not to say that there is not an enormously important place for mere presence - which, after all, may be the most important ingredient in care - or for seemingly just talking about what may appear to be trivial or banal topics (Schneidman, p. 207).

In 1978, the term oncotherapy had not yet been born. Schneidman's use of the term thanatology is in reference to the end stages of advanced disease - that of death preparation. Oncotherapy, on the other hand, encompasses death preparation at the end stage of a continuum of advanced disease. Thanatology, therefore is one facet of oncotherapy and requires skills and commitments that distinguish it as subspecialty.

For those engaged in cancer psychotherapy, counseling the advanced cancer patient means dealing with real physical

Table 2

Contrast Between Conversation, Psychotherapy and Oncotherapy

	In a conversation the focus is on:	In a professional exchange the focus is on:	In a thanatological situation the focus is on:
Content	1. Substantive content, i.e., the talk is primarily about things, events, dates--the surface of the world.	1. Affective (emotional) content, i.e., the exchange focuses (not constantly, but occasionally) on the feelings and the emotional tone of the patient, sometimes minimizing the facts.	1. The topics of death & dying. It is not the clinical thanatologist who introduces these topics. The dying person will, if permitted, bring them up, because those topics are understandably upper most in the patient's mind, except when they are denied. The important point to be noted is that when these topics do come up, as they almost invariably do, the thanatologist does not run from them, or from the patient.
Level	2. Manifest level, i.e., conversation focuses on what is said, the actual words, which are stated.	2. Latent level, i.e., the professional person listens for what is between the lines and below the surface, for what is implied, not	2. Both manifest and latent levels. The manifest levels may come to include topics around death: burial arrangements, disposition of

Table 2 (continued)

In a conversation the focus is on:	In a professional exchange the focus is on:	In a thanatological situation the focus is on:
Meanings	3. Conscious meanings, i.e., dealing with the other person as though what was said was meant and as though the person were a "rational man" and "knows his own mind."	3. Unconscious meanings, i.e., listening for unconscious meanings and latent intentions (e.g., double-entendres, puns, hidden meanings, latent implications, etc.)
	expressed, for what may be unconsciously present.	belongings, etc.; the latent meanings of many of those over arrangements may involve the wishes for continued control, for extension of life, and for certain kinds of immortality. In the dying scene there are both coded messages and statements of breathtaking candor.
		3. The distinction between conscious and unconscious meanings is complicated in the dying scene by the very irrationality of death itself. It is difficult to be rational about the end of one's own life and ceasing to be. The clinician listens, tries to comprehend, and is sparing with interpretations, knowing

Table 2 (continued)

	In a conversation the focus is on:	In a professional exchange the focus is on:	In a thanatological situation the focus is on:
Abstrac- tion	Phenotypic, i.e., concern with the ordinary, interest- ing details of life, where what is talked about is the same as "what is meant."	4. Genotypic, i.e., search for congruencies, similarities, commona- lities, generalizations about the patient's psychological life.	that comfort and peace of mind are more important than new insights when one is racing the clock. 4. When the thanatologi- cal interchange is geno- typic, it focuses on the other comparable periods of the dying person's life: episodes or instances of stress, threat or failure, other "little deaths" or endings, previous patterns of premourning. Of course, earlier times of triumph, success, and happiness are neither neglected nor depreciated. In all this, the patient sets the pace.
Role	5. Social role, i.e., an exchange between two people	5. Transference, i.e., exchange is between nonequals; between one	5. The most important difference lies under this rubric. If one

Table 2 (continued)

In a conversation the focus is on:	In a professional exchange the focus is on:	In a thanatological situation the focus is on:
<p>who are essentially equals (like neighbors or friends, etc.) or who depend on the prestige of age, rank, status, etc., but who have an equal right to display themselves, to ask each other banal or intimate questions, neither being the patient.</p>	<p>person who wishes help (and tacitly agrees to play the patient's role) and another person who agrees to proffer help (and thus is cast in the role of physician, priest, father, magician, witch doctor, helper). Much of what is effective in the exchange is the patient's transference onto the therapist.</p>	<p>chooses to work intensively with a dying person, then one can deliberately attempt to create a situation of rather intense and deep transference from the patient to the therapist (and, along with it an intense countertransference from the therapist to the dying person). It is unlike any other situation. The stark reality is that the patient will die soon, so that ethically speaking, the therapist can afford quickly to become a key, significant figure in the dying person's life.</p>

Shneidman, E.S. in Garfield, C.A. (Ed.) (1978). Psychosocial care of the dying patient, pp. 207-209. Reprinted with permission of the publisher, McGraw-Hill Book Company.

problems vs. a physical problem existing in the mind as a hysterical reaction or neurotic obsession.

Shibles (1974) notes that it is thought to be more rewarding to help people recognize a problem, deal with it, get "well" and go on to a more enriching and rewarding life style. Such is not the case for an oncotherapist and client. For the cancer patient, one problem quickly follows another and they never really get "well". While the quality of life is hopefully improved by the counseling process, a truly comfortable and rewarding life style may not be realistically possible. In addition, the chance for long term follow-up does not exist, since when the mutual relationship ends, it is more final when it ends in death.

Despite the differences, there are similarities in the psychotherapy and counseling done with those living with cancer and others who seek psychological help with life's difficulties (see Table 3). The relationship skills and techniques that are developed through traditional counseling responsibilities are transferable to some problem situations involving those experiencing a life threatening illness.

Table 3

Oncotherapy and General Psychotherapy Compared and
Contrasted

Oncotherapy (Flexibility of setting)	General Psychotherapy (Standardized setting)
- Referral may be self-initiated or made by the medical management team.	- Referral to therapist may self-initiated or other initiated.
- Therapist may be an M.D., Ph.D. or other health/medical person, i.e. MSW, MSN, pastor.	- Therapist may be M.D., Ph.D., M.A., MSW, MSN, pastor.
- Therapy is usually an adjunct of medical treatment.	- Therapy may or may not be an adjunct to any other therapy.
- Therapist may see patient independently, but generally is a member of a team, working in conjunction with others.	- Therapist is generally independent of others in treatment of client.
- Therapist may need to act as liaison between patient, family and members of the health team.	- Therapist may need to act as a liaison between patient and family and at times may consult with patient's physician.
- Therapy may be with individual, spouse, family or group.	- Therapy may be with an individual, spouse, family or group.
- Sessions may vary in frequency and length dependent upon patient's medical treatment and physical discomfort.	- Sessions are at regularly scheduled times with length generally 50 minutes.

Table 3 (continued)

Oncotherapy (Flexibility of setting)	General Psychotherapy (Standardized setting)
- Therapist encounters patient with physical plus emotional pain.	- Therapist encounters patient with emotional pain which may result in physical symptoms.
- Specialization skills may be limited to one diagnostic group i.e., leukemics.	- Specialization skills may be with one diagnostic group i.e., alcoholics.
- Therapist must have working knowledge of crisis intervention.	- Therapist may or may not have working knowledge of crisis intervention.
- Therapist frequently deals with issues of body image.	- Therapist may or may not deal with issues of body image.
- Therapist must be required to work through the separation loss anxiety of own death prior to clients.	- Therapist may not be required to deal with own death/separation type of loss anxiety prior to clients.
- Physical problems are viewed as real.	- Physical problems may be viewed as neurotic.
- Fatigue may be first viewed as expected problems of disease progression or side effect of chemotherapy, and radiation.	- Fatigue may be first viewed as a symptom of depression.
- Depression in response to illness may mask an underlying anger.	- Depression as a symptom, may mask an underlying anger.
- Suicide may or may not an issue.	- Suicide may be an issue.
- Care matters more than cure.	- Goal of sessions are aimed at cure.

Table 3 (continued)

Oncotherapy (Flexibility of setting)	General Psychotherapy (Standardized setting)
- Therapy may be of short or long duration - dependent upon stage of illness when first seen by therapist.	- Therapy may be of short term or long duration.
- Goals are short termed and aimed at helping patient live with probability of increasing dependency.	- Goals may be short or long termed aimed at helping person to be independent and productive for future.
- Approach may be support vs. psychoanalysis.	- Approach encompasses support and may or may not be psychoanalysis.
- Client problems and dependency needs generally increase over time.	- Client problems and dependency needs expectantly decrease over time.
- Group sessions may be with those sharing same diagnosis i.e., breast cancer, leukemia, AIDS, etc.	- Group sessions may be with those sharing same diagnosis i.e., schizophrenics, bulimics, alcoholics, etc.
- Behavior modification may be appropriate for reduction prior and during medicine.	- Behavior modification may be utilized for symptoms interfering with daily living.
- Patients tend to be more open - "what have I to lose" and progress rapidly through therapy with strangers.	- Clients may be more guarded without the urgency of a life time factor, and cling to inhibitions.
- Termination with client is likely to be through death.	- Termination of client may or may not be through death i.e., suicide, since goal is for cure.

Table 3 (continued)

Oncotherapy (Flexibility of setting)	General Psychotherapy (Standardized setting)
- Fees - collected from individual, insurance company or ACS or other charitable organization.	- Fees - collected from individual or insurance company.

Once that stage of death certitude is reached as a "constant", the goals and rules that distinguish the gap of oncotherapy from general psychotherapy becomes more clear. The goals of living through each day evolve to the omnipresent goal of providing psychological and physical comfort. The rules are modified in these and stages when there is a foreseeable death date. Schneidman (1978) states:

The celerity with which the relationship between a therapist and patient is established, as well as the depth of that relationship, is totally appropriate for a dying person, while for the ordinary patient, it might appear unseemingly and even border on the unprofessional (p. 210).

He expresses the opinion that this may not be psychotherapy yet it may be psychotherapeutic. Working through certain feelings may be a luxury for those who have time to live. "Nor is there any natural law that says an individual has to achieve a state of psychoanalytic grace or any other kind of closure before death sets its seal" (p. 206).

Counseling vs. Psychotherapy

In his extensive research regarding this topic, Renneker (1981) does not make a distinction between the role of counselor vs. psychotherapist in terms of the type of therapy offered cancer patients. Schneidman (1978) when referring to the role of thanatologist says only that the person may be a physician, psychologist, nurse, social worker or any trained person. Hackett (1976) agrees that counseling work done with the cancer patient can be

implemented by those in the health care setting according to their area of expertise to meet patient needs.

Because the terms counseling and psychotherapy are frequently used interchangeably in the literature, the result appears to be much overlap in the work done by the various disciplines in the health care field as they attempt to help the client adapt and cope with their illness. While some commonalities in philosophies and methods exist, counseling and psychotherapy are different. This difference in roles has been discussed at length by two nurse authors. Burkhalter (1978) states that: "The primary differences between counseling and psychotherapy lie in the nature of the patient-helper relationship and the problems addressed" (p. 228). She points out that psychotherapy has a greater focus on 1) identifying intraphysic dynamics; 2) changing personality structure or overt behavior to enhance life functioning; and 3) severe emotional or psychological problems i.e., neurosis or psychosis. She compares this focus to the goals of counseling with the oncology patient and lists them as the following when seeking to aid or assist the client.

- 1) Identify problem areas that are having an adverse impact on functioning
- 2) Resolve identified problems
- 3) Mobilize resources prior to problem resolution
- 4) Make plans or devise coping strategies
- 5) Reduce conflicts that impede effectiveness
- 6) Adjust to nonmodifiable stressors both internal and external in origin
- 7) Effect needed behavior change
- 8) Enhance feelings of effectiveness and satisfaction

with living (p. 229).

It would appear that these goals are applicable to any counseling client and not necessarily limited to someone with a physical illness. These goals are intended to serve as useful guides for the skilled helper and follow a problem solving approach.

DePastino (1984) has outlined an even clearer distinction between counseling and psychotherapy in Table 4, p. 95 of her article, "The Nurse as Counselor".

Table 4

A Comparison of Counseling and Psychotherapy

	Counseling	Psychotherapy
Client:	"Normal"	"Sick"
Reference:	Present/Situational/ Conscious	Past/Depth/Unconscious
Focus:	Supportive/Educa- tional/Problem-Solving	Analytic
Goal:	Coping/Adaptation/ Growth	Cure/Reconstruction
Duration:	Short-term	Long-term

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Counselor Preparation

Burkhalter (1978) notes that the parameters of the counseling process are defined by the skills of the counselor, environmental influences and the patient's ability to respond. Merely having the desire to do oncotherapy is not enough. The qualities of openness, acceptance, attentiveness, understanding, empathy, warmth and honesty are desirable. These may not be static components of the therapist's personality but it is expected that they develop and sharpen with experience.

The preparation for the role of a cancer counselor has been addressed by several authors. Renneker (in Goldberg, 1981) summarizes some prerequisites to engaging in cancer psychotherapy.

- a. A psychotherapist must have prior knowledge about the range of coping problems with which cancer patients are confronted.
- b. A psychotherapist must have prior knowledge about the probable inevitability of his experiencing disturbing emotional reactions to helplessness-hopelessness, identification with cancer patients and to dying and death.
- c. The personality and life history of a psychotherapist are probably critical factors in determining whether or not he should attempt fighting/coping psychotherapy.
- d. A psychotherapist must have prior knowledge of the available assumptive psychodynamics and life history patterns of cancer patients as contained in the literature.
- e. A psychotherapist must have prior knowledge of the therapeutic orientation, principles, methods and procedures utilized by others in their fighting/coping therapy efforts (p. 164).

A working knowledge of a needs assessment for the developmental stage of life of the client is basic to any intervention process. Knowing where the person is in life, aside from their illness, will provide a basis from which to begin. The developmental stage of the person and the family affect needs and adjustments required for coping with cancer. "Specific knowledge of cultural and societal values, relevant literature and one's own philosophy on life and death are pre-requisites to offering help" (Thompson, Dicterson, & Wester, 1975).

In addition, Klagsbrun (1983) believes that those individuals working with advanced cancer patients are in need of (1) medical and related knowledge, (2) skills in family therapy techniques, and (3) leadership skills. Because much of the care of the cancer patient requires problem solving and crisis intervention, these skills need to be introduced and developed under guidance. For the beginning therapist, a review of Freidenberg's et al. (1980) assessment instrument for a structured problem-oriented interview designed to illicit the psychosocial problems of cancer patients, might prove helpful.

Shibles (1974) and Schneidman (1970, 1971) offer questionnaires which can be utilized as a procedure for introspection by those who desire to work with clients seriously ill and whose death is eminent. It is strongly suggested throughout the literature, that those working with

advanced cancer patients, whether or not they are dying, having other clients who do not have cancer. Strong role models are needed by the person embarking on advanced training in oncotherapy regardless of whether a beginner or seasoned therapist. The transference and countertransference as well as other issues which surface, need to be recognized and dealt with in a manner that is most helpful for both therapist and client by an objective other person. It is considered a basic requirement that the therapist have his or her own strong support system and that one's social life be full and active and generally free of personal crisis (Amenta, 1981; Bugan, 1979; Burkhalter, 1978; Goldberg & Tull, 1983; Klagsbrun, 1983; Kookcher, 1979; LeShan, 1977; Momeyer, 1985; Weisman, 1981). "It is important to have one's own house in order to effectively intervene with a client facing a life threatening illness" (Abrams & Vispo, 1971). Inattention to or lack of awareness of one's own emotional life will set the stage for a masquerade of platitudes lacking needed substance when time is of an essence.

Cancer counselors are considered more vulnerable to a variety of negative anxiety experiences when they lack self-awareness. These feelings may include inadequacy, anger, guilt, helplessness or frustration (Hinton, 1971). Aversive feeling states may lead counselors to hide behind facades of formalities, duties (Weisman, 1970).

Weisman (1981), a psychologist at Massachusetts General Hospital, states that, "caregivers can sometimes be more distressed by the plight of their patients than are the patients themselves." In extreme instances their vulnerability leads to what is called "caregivers plight". He describes this as "a set of responses which interfere with adequate understanding and may result in progressive vocational demoralization, change to another field, and drastic impairment of self esteem. This caregiver's plight might also be referred to as "burnout". However, Vachon (1979) points out that the personal and professional problems which caregivers develop in terminal care settings can be traced to their own frustrations and motivations and that the caregiver's plight is much more than "burnout." It can and does involve the patients and it is possible that some of the distress experienced by hospitalized cancer patients might be iatrogenic in origin and the result of emotional burdens felt by caregivers and secondarily placed on patients. Weisman offers therapeutic suggestions for identifying and correcting such a state. He includes "knowing how to cope better, and how much to promise, sharing concern with colleagues, attempting to make smaller contributions and using an exercise called 'Absent Witness,' an imaginary self-monitoring review" (p. 161). Further, he identifies "good coping" for the counselor as a "a combination of optimism, resourcefulness, flexibility and

pragmatism" (p. 166).

Bugan (1979) is in agreement with Vachon and says that counselor's perceptions of persons with a life threatening illness may reflect the counselor's own discomfort, not necessarily that of the client. In his study on Anxiety Effects on Counselor Perceptions, Bugan states that "high-level anxiety states are clearly important factors in counseling relationships and require a special focus when clients face a life-threatening illness." His study demonstrated that counselors differentially perceive clients on the basis of their own anxiety levels.... For instance, high-anxious counselors may be willing to avoid discussing death-related matters in order to "respect a cancer patient's denial" (p. 90). The implication to be considered is whether the relationship between anxiety state of the counselor and differential perception of clients may relate to other more basic losses.

Those engaged in oncotherapy find that therapy, more frequently than not, progresses rapidly with the client and can be enriching. Generally embarrassment and resistance to feelings is not as common with these clients as with others. There is a greater tendency toward the attitude expressed as--"what have I got to lose!" A flow of strength and candid open sharing of feelings by the patient/client has been known to overwhelm and astound therapists to speechlessness. Such candid sharing plus a barge of

conflicting feelings eventually help the therapist to gain new awareness of the meaning of life, growth, pain, being and becoming. "Therapy comes to be viewed as a cooperative relationship and the newer therapist in particular is faced with many basic theoretical issues - self-disclosure, control, professionalism and termination" (Curran, 1980, p. 343).

A variety of counselor/oncotherapy preparation programs exist as university based as well as continuing education models. The master's level of preparation of nurses and social workers make these people amendable to the more specialized work of oncotherapy. For the nurse, the stress of having to learn medical terminology and pharmacology has already been experienced. If oncology has been her specialty, it is assumed she is already clinical adept in the area of cancer care encounters. Because cancer is not just one disease entity, the oncology patient experiences a multitude of stressful events over the course of diagnosis, treatment and progression of disease. His needs are many and varied and may require spontaneous intervention and the use of wide repertoire of knowledge and skills acquired by the nurse. It is paramount to know one's limits of helping ability and to seek out others on the team who might be even better equipped to help. Mental health professionals can play important roles on multidisciplinary oncology teams, however, expecting them to shoulder the entire burden of

direct service for cancer patient's psychosocial needs is unrealistic according to Rainey et al. (1983).

Bugan (1979) makes several suggestions for counselor training programs. He believes programs should continue to reflect a strong personal growth orientation through experiential learning. He is in agreement with Weisman (1970), Hinton (1971), and others who insist that counselors become sensitive to their own affective state during therapeutic encounters. He further suggests that multiple therapy involving two or more helpers will allow for more reliable and valid perceptions of clients. Counselors should frequently give their clients feedback as a further check on counselor perception. Supervision on a consistent basis is necessary.

In addition to university programs in psychology, social work, nursing and pastoral care, other training programs in the psychosocial aspects of cancer care exist throughout the country. One such program developed by Rainey et al. at the Jonsson Comprehensive Cancer Center at the University of California at Los Angeles has been the model successfully implemented in community hospitals and medical centers as part of community-based cancer control programs.

The Simontons in Houston conduct an extensive program which is limited to their specialty of meditation and visualization. Most training programs can be expected to

involve a six month to one year time frame. The costs for such programs are variable and can range from being cost-free to several thousand dollars.

Before seeking out a program, a counselor might wish to review the literature concerning types of counseling needed by oncology patients. An article written by Ronald Koenig, M.S.W. at Wayne State University, entitled "Counseling in Catastrophic Illness: A Self-Instructional Unit" (1975) gives the reader a sympathetic understanding of what to expect in a helping relationship with a cancer client.

Implications of Cancer Proneness

In a two year period between 1978-1980, 600 papers had been published on the psychosocial aspects of cancer. There continues to be a pronounced interest in this field with multitudes of publications on all the various aspects of cancer care interventions.

Matje's (1984) intensive review of stress and cancer identifies three current themes in the literature relating psychological factors to cancer. They are: 1) past experiences, 2) specific personality patterns, and 3) recent life events associated with loss. Other themes in the literature include the area of genetics and general life style behavior patterns as well as environmental pollutants as causes of cancer.

Why is it necessary to consider any of these themes prior to psychological intervention with the cancer patient?

The goal is certainly not to instill guilt by placing blame on the person or by trying to find a reason for the cancer, but rather to grasp the health inventory of a person's life style and learn how they generally approach life concerns and crisis. It should be kept in mind that the focus of intervention with the cancer patient is to maintain or improve the quality of life however long that life might be for a terminally ill person. Knowledge of a client's usual focus or locus of control in life is needed in order to better understand potential risk factors. In addition, an understanding of their general personality structure may be used in a conjoint effort to help clients employ their strengths effectively in combating further illness. The strength in preventive medicine lies in a keen awareness of predisposing factors and then acting upon this knowledge.

Stress and Past Experiences

Smith and Sebastian (1976) state

One of the less visible theories claims that stress and emotional states predispose some people to cancer, even though, the possible cause-and-effect relationship must be complex and are unknown at the present time (p. 863).

They hypothesize in their exploratory study that the history of emotional states in one's life would have a relationship to the pathogenesis of cancer in a group of human subjects. The implications of the study have to do with diagnosis and prevention. They suggest that emotional history evaluations be used as a screening method to identify people with high

probability of developing malignancies and further suggest that such an evaluation be combined with traditional medical methods of treatment.

A relationship between stressful past life experiences and cancer have been studied by numerous other investigators, among them: Snell and Graham (1971), Solomon et. al (1974), Lazarus (1974), Grissom (1975), Greer and Morris (1975), Achterberg, Simonton and Simonton (1976), Lazarus and Launier (1978), and Scurry and Levin (1979) to name a few. All support this relation with the exception of Scurry and Levin's extensive 1979 study which concludes that life events studies examining stress and cancer all have methodologic problems and contend that the available data does not support the two. However, the content in the numerous studies that have been done cannot go unnoticed.

The identification of stress as an intervening variable in physiological well-being generates some interesting questions. Because all humans are subject to stress, all should be subject to some manifestation of cancer. Attempts to quantify the effects of stress to establish correlates between magnitude of stress and magnitude of anomaly do not account for variations in incidence of cancer among humans. ...it is not the incident or event that interplays with the individual physiologically, but the individual's perception of and response to the event that defines the event as stressful (Pusateri-Vlach & Moracco, 1981, p. 269).

While it is a known fact that everyone harbors oncogenies (cancer cells) in their bodies, the disease does not manifest itself in everyone; something acts to trigger these aberrant cells into a recognizable pathology and illness. Sulls and Mullin (1981) proposed that events with

an element of uncertainty are more likely to compound a stressful experience and thereby act as the trigger. In the cognitive state of uncertainty, events are evaluated as threatening due to the inability of the individual to accurately predict the impact of the situation. The locus of control is outside of oneself and a feeling of helplessness exists. This is especially significant when the experience is an unfamiliar one involving an important aspect of life such as survival and health. When options are unable to be grasped, stress is increased and a state of both hopelessness and helplessness prevail.

From the medical standpoint, psychosocial stress is substantially associated with a low lymphocyte count, which in turn is a strong risk factor for cancer. There are those who disagree with the interplay of stress and physiologic consequences.

Psychosocial stress in terms of hopelessness, high antiemotionality, etc. has a strong relevance for cancer incidence which does not act via one of our physiologic variables associated with cancer (Grossarth-Maticek, 1982, p. 193).

However, it is known that psychological events can cause endocrine changes and that endocrine changes can modulate immune responses resulting in cancer susceptibility. This pathway of psychological imbalances and the neuro-endocrine and immune systems response have been implicated in certain kinds of cancer, namely the hormone response tumors of the prostate and breast (Stoll, 1972). There is also evidence

that strong emotional arousal leads to changes in circulatory levels of catecholamines, corticosteroids, growth hormones, prolactin, thyroid function, androgens and estrogens (Levi, 1972; Stoll, 1976).

Over time, stress has been studied in terms of major life change events and one's perceived locus of control. There seems to be a slow change in focus during recent years from the study of major life events that have a sudden impact on the immune system, to a present concentration of noting an individual's chronic ongoing accumulation of stress of daily life that contributes to illness. One's locus of control over these daily stresses are viewed as significant in terms of personality and illness.

With this in mind, it would seem logical to early on provide those person's identified to be at high risk with some form of stress reduction therapy to help decrease the odds of cancer development or progression.

Personality

A recurrent pattern in the psychological literature concerning certain behavior characteristics of a cancer prone personality, heretofore referred to as Type-C, describes the individual as diligent, hardworking, with a chronic sense of time urgency, frequent bouts of guilt, generally non-assertive, lacking close personal relationships, possessing tendencies toward anxiety/depression and lacking emotional catharsis. This

describes the person most likely to be selected by the Type-A employer who might be looking for a like perfectionist to do a good job, keep company confidences, and not likely to challenge authority. In addition, a premorbid personality has been credited with a cause-effect relationship in the development of cancer. Dattore (1980) has sited many of the studies that support this view.

Mental depression, grief, anxiety and intense disappointment have all been attributed as antecedents of a cancer diagnosis with repression being the hallmark of the premorbid personality. Abse (1974) describes other personality characteristics of cancer patients namely, denial, rigidity, conformity and a self-critical attitude.

Greer (1979) postulates that psychological factors, through their influence on homeostatic controls and on behavior, contribute to cancer susceptibility in certain individuals. Having already developed cancer,

the manner in which individuals cope ... is dependent upon their personality type, premorbid emotional status, values, activities, relationships and previous and concurrent life events" (Krumm, 1982, p. 729).

Holland (1977) and Wellisch and Yager (1984) strongly denounce the presence of a cancer prone personality. Below are some of those who support and who denounce this theory.

Type C Cancer Prone Personality

Support

Thomas, 1974
 LeShan, 1977
 Smith and Sebastian, 1976
 Scurry and Levin, 1979
 Abse et al., 1974
 Greer, 1979
 Cassileth, 1985
 Fox (agrees with caution), 1983

Denounce

Holland, 1977
 Wellisch and Yager, 1984
 Jory Graham, 1980 (Sun
 Times Columnist)
 Marcus, 1976

Those who strongly denounce a cancer prone personality do so on the grounds that knowledge of this by the patient would place an onus on the person and make him feel responsible for his illness, and thereby create reactive anxiety, guilt and depression.

This investigator finds it contradictory that while much credence is given to the Type A coronary prone personality, it is with much crepitation that the same recognition is withheld or given with hesitancy and reservations to the Type-C cancer prone personality. Recommendations for decreasing stress levels, attitude change, change in life style and dietary habits as well as active participation in one's care, have become acceptable means to overt and reverse heart disease. The link between heart disease and diet is yesterday's news. Yet, the suggestion that high fat, high cholesterol diet increases the hereditary risks for breast, prostate and colon cancers is quite new. It took the notoriety of President Reagan's illness to enlighten the nation and somehow make this idea okay. The link between stress and cancer is still viewed

pessimistically both by the medical profession and the general public, while the stress/coronary heart disease concept relationship is reverently accepted.

Much of the work done in the psychosocial intervention with cancer patients has been retrospective of the disease diagnosis. Craig and Abeloff (1974) and Napier et al. (1972) question if the awareness reaction to cancer alters personality and recall. The MMPI is a frequently used tool to measure personality profiles in these studies. However, since it is a tool designed to measure psychopathology, it may not be sensitive to personality variables within the range of normality (Scurry & Levin, 1978).

In her 35 year longitudinal study using Johns Hopkins medical students, Thomas' (1979) data suggest that cancer tends to occur in persons who are low-key, non-aggressive and unable to adequately express emotions. Many victims tended to be lonely and without close parental relationships. This view is supported by LeShan and Worthington.

The work done by LeShan and Worthington is retrospective in nature with persons who had already developed cancer. Thomas' longitudinal study began with healthy subjects with personality characteristics similar to those cancer victims in LeShan's studies, and who later also developed the disease. Thomas found that years prior to diagnosis of cancer, her subjects had perceived less

closeness to parents than did any other disease group studied. No study has yet been found that documents an isolated Type-C personality without also taking into account the stress of past experiences and recent life events.

Recent Life Events Associated with Loss

Lawrence LeShan, a New York psychoanalyst, retains the distinction of having worked in a psychotherapeutic relationship with cancer victims longer than any other investigator. His interest has been in the events of life history pattern frequently observed in cancer patients. Through personal interviews, questionnaires and the use of the Rorschach technique, he has concluded that the most important factors in the development of malignancy is a felt intense loss, with a sense of associated hopelessness and helplessness, an inability of the person to express the rebound anger or resentment, marked self dislike and distrust, and recent loss of an important emotional relationship (LeShan, 1977). Too often anger, especially in those without significant others, except health care workers, is repressed for fear of reprisal. Vachon and Lyall (1976) site the example of the patient who is angry with his physician but fights to repress the expression of his feelings. "If I get angry at the doctor, he may refuse to treat me. Then what will happen to me at this most desperate period of my life" (p. 583). Anger then tends to be displaced onto less powerful people, frequently the

nursing staff or laboratory technicians. When no outlet is available, the anger is turned inward.

Some losses that a person could experience that might contribute to illness include loss of a job and/or retirement. While retirement may come as scheduled in one's life, a forced early retirement due to job lay-offs is becoming common place. Frequently at the time of job lay-offs, all benefits are cut, leaving one not only without employment but also without retirement compensation and insurance benefits at a time in life when these are most needed.

Loss of a spouse at any age is significant in terms of grieving and health of the survivor. Personal experience in working with an oncology population, is that when one partner dies, the survivor frequently becomes ill within the year--frequently with cancer.

Major disasters and the loss of property through flooding or fire resulting in the removal of past memories via photographs, etc. may be perceived as a loss of a part of one's identity. A compounding of multiple losses with limited time between each for adequate grieving, can lead to feelings of hopelessness and helplessness, and result in near future illness.

Schmale and Iker (1971) state that two distinct factors are at work in the process of carcinogenesis, one an initiating factor and one a promoting factor. Cellular

dysplasia has been indicated as the initiator of cancer while the psychological experience of hopelessness acts as a promotor of this disease. This finding is in accord with those of LeShan. Their study involved healthy women subjects considered to be biologically predisposed to cancer of the cervix based on suspicious Papanicolaou smears. They predicted that those women with a "helplessness prone personality" would be the one's diagnosed with malignancy and that those expressing more hope in their lives would not develop cancer.

It can be concluded that the consistent theme in the studies conducted by LeShan, Thomas and Schmale and Iker are the emotional factors of hopelessness/helplessness and that anything which can promote hope and a sense of personal control might be able to retard progression or to reverse the disease altogether.

Research has shown that the lack of available options during periods of conflict tend to increase stress and hopelessness. This needs to be kept in mind when attempting to do any psychological intervention with those persons having cancer. Reduction of stress versus increasing stress may prove to be more beneficial for the psyche and the immune system. This does not mean that confrontation in graduated doses is undesirable; quite to the contrary. Some confrontations may help to release anger and a resulting sense of relief may be obtained.

other Factors

One needs to consider the other risk factors of inheritance, occupation, environmental hazards and behavior patterns in addition to stress, loss and personality factors that determine oncogenesis.

The interpretation of associations between psychosocial factors and the incidence of cancer is complicated by the possibility that these may be linked to cancer through other risk factors which are behaviorally determined. Smoking, a clear cancer risk factor is associated with certain personality characteristics (Smith, 1970). Alcoholism and cancer of the liver and pancreas are associated. Exposure to sexually transmitted infection is a determinant in carcinoma of the cervix.

How to alter behaviors which increase cancer risk or increase progression of already diagnosed disease is a task of formidable proportions. Tobacco, alcohol, known carcinogens and excessive exposure to sunlight are all potentially controllable aspects of behavior. It is estimated that issues which have to do with life style, particularly the components derived from diet and cultural habits, account for 60% of cancers in women and 30% in men (Higginson & Muir in Holland, 1981). These factors and others can be controlled in the research design, however, this has not always been done which is why much of the research in this important area has lost credibility (Scurry

& Levin, 1979).

Greer (1979) relates that psychological inquiry has contributed to cancer research in the following areas:

- 1) communication between doctors and patients;
- 2) identified causes of delay in medical consultation among cancer patients;
- 3) progress of cancer patients after treatment in terms of their psychological and social adjustment; and
- 4) the possible role of psychosocial factors in the etiology of cancer.

If emotionality is related in some way to pathogenesis of cancer, counseling and psychotherapy may prove useful to prevent occurrences of the high intensity emotional states that have been studied in the review of research. There appears to be justifiable need for emotional intervention before cancer occurs for those predisposed and at high risk for development of the disease. While some attitudes and behaviors may be more difficult to alter once illness has occurred, clients may be more willing to accept psychologically oriented interventive methods, if for no other reason that to be in the company of an empathic other person.

Psychotherapeutic Interventions

At the third National Conference on Human Values and Cancer, held in 1981, J.W. Worden, Ph.D., a prominent researcher at Boston, Massachusetts General advocated three

basic philosophies of possible intervention with cancer patients.

The first would be to provide psychological services to everyone. This, however, is generally not cost effective and many patients do well on their own without special intervention. The second philosophy would be to wait and see who gets into serious emotional difficulty and then refer them to the social worker or psychiatrist. The third philosophy concerns preventive mental health. If at all possible it is best to identify in advance of serious distress, the patients at highest risk and offer help before serious problems or poor coping develop.

Krumm (1982) reports that Freidenbergs and associates (1980) have identified three basic types of psychological intervention for cancer patients. The first is providing education to assist both patient and family to live with the disease. The second type is counseling, where the client is encouraged to express feelings and ventilate emotions. The counselor offers support, reassurance, and assistance in clarifying these feelings. The third type involves consultations with other health care personnel about specific areas of concern. Formal referrals may be needed when trying to manipulate the environment to accommodate patient needs. Arranging for consistency of interactions with care providers is important, though too often neglected.

These intervention strategies coincide with the three major needs of cancer patients:

- 1) to maintain control over one's destiny;
- 2) to understand the technical language or procedures associated with treatment; and
- 3) to share one's feelings and thoughts.

Impaired bodily functions and psychological reactions to physical impairment are natural components in chronic progressive disease. Conflicts and anxiety are a natural part of the struggle to cope with the threat of cancer to the integrity of the body, the impairment or loss of bodily functions and the potential effect upon the life and the world in which he or she must live. The uncertainty of the outcome of the disease and life itself influence one's thinking and behavior. Krumm is in agreement with the advocates of pre-cancer personality when she asserts that the manner in which individuals cope with their disease and treatments is dependent upon their personality type, premorbid emotional status, values, activities, relationships and previous and concurrent life events.

Abram (1971) has identified the unconscious and nonvoluntary psychological defenses of chronic illness. These include regression to earlier comforting behavior, denial, intellectualization, projection, displacement and introjection. The manner in which these defense mechanisms are used will determine the psychological reactions of the

client to his illness. Throughout the terminal stages of cancer, the patient's psychological responses vary. The responses of anger, denial and regression may occur and recur as the patient experiences physiological, social and psychological changes. Any counseling done with cancer patients necessitates it as an adjuvant therapy to the more traditional medical treatments of chemotherapy, surgery, and radiation. Since the function of mind and body are interlocked, one cannot treat one without due recognition of the other as a reciprocal entity.

Two Major Philosophies Compared and Contrasted

There appears to be two different philosophies of psychological intervention for a client with advanced malignant disease. The first is advocated by Larry LeShan and is focused on helping people to live and fight for their lives no matter how close to death they might be. The second, advocated by Kubler-Ross is focused on helping people live full and enriched lives but with the realization and resignation that death is in the near future; the future of death rather than a future of continued life becomes the recurrent theme.

LeShan sees his counseling philosophy as quite different from that of Kubler-Ross, yet both are helping people to make discoveries and fulfill their lives in ways never before explored. While LeShan deals with the problems of living with the disease, Kubler-Ross does the same but

goes a step further and explores more the dying process. Both philosophies deal with terminal illness; however, Kubler-Ross deals mainly with the terminal phase of terminal illness. While both are patient-centered caring, Ross tends to also include family members, a practice not necessarily promoted by LeShan. Silverfarb (1982) suggests that fostering of acceptance of death in Kubler-Ross's approach with clients in the end phase of terminality, may be antitherapeutic doing earlier phases of disease.

The following is a compiled list from several major contributors (Felton/Revenson, 1984; Fredette/Beattie, 1986; Stam et al., 1986) of those issues encountered by the cancer client and counselor when facing a progressing cancer prognosis.

Tasks/Needs/Concerns of Person Living with Cancer

A. Instrumental

Knowledge/Information

Disease-cancer the multiple illness

Specific cancer terms

Symptoms of cancer

Treatments and alternative treatments

Financial difficulties

Transportation, equipment and housing needs

Available resources

B. Health Care System

How it works

How to manage it

Static relationships with care provider

Difficulties complying with treatments

Real and imagined concerns of abandonment

C. Personal

Feelings

- Denial, depression, fears, pain, anxiety, grief, anticipatory grief

- Identifying, expressing, exploring, understanding

- What is ok

Body image concerns

Energy level changes

Role change

Sexuality

Nutrition

Stress of disease and general life stresses

Coping responses

- Identifying, expressing, exploring, understanding, changing

D. Physical-somatic complaints

Cognitive impairment

Pain

Nausea/vomiting

Diarrhea/constipation

Physical treatments and diagnostic tests

E. Support Systems Concerns

Involvement of significant other
Impairment in relationship with family
Church/religious beliefs
Friends

Coping and Locus of Control

Coping with these special needs, tasks and concerns takes much emotional and physical energy on an almost daily basis. The word "cope" is derived from the French word "couper" which means "to strike". The derivation is very appropriate for cancer patients because successful and successive strokes, movements, and accomplishments will allow those with cancer to take or regain control of their lives (Fall, 1987).

The literature indicates a division among the contributors concerning required new vs. old coping behaviors for cancer patients. Some authors have commented that knowledge of serious illness such as cancer with impending death follow previous coping patterns (Aguilera, 1974; Schneidman, 19 ; Hinton, 1975); while others (Viney, 1984; Miller & Nygren, 1978) assess that new and/or additional coping behaviors are required in order to adapt and improve quality of life.

Coping is defined, by Weisman (1979), as "what one does about a problem in order to bring about relief, reward, acquiescence, and equilibrium." Coping is not just one set of isolated actions but is a process which combines

perception, performance, assessment and restructuring of goals, followed by further motivated action.

Some general ways in which people tend to cope are:

- 1) Seek more information (rational inquiry)
- 2) Share concern and talk with others (mutuality)
- 3) Laugh it off and make light of situation (affect reversal)
- 4) Try to forget (suppression)
- 5) Occupy self with activities for distraction (displacement/redirection)
- 6) Take firm action based on present understanding (confront)
- 7) Accept but find something favorable (redefine/revise)
- 8) Submit to the inevitable; fatalism (passive acceptance)
- 9) Do something reckless or impractical (impulsivity)
- 10) Negotiate alternatives (if X then Y)
- 11) Excessive drink, drugs, danger (life threats)
- 12) Withdraw into isolation; get away (disengagement)
- 13) Blame someone or something (externalize/project)
- 14) Seek direction; do what you're told (cooperative compliance)
- 15) Blame self; then sacrifice or atone (moral masochism) (Weisman, 1977, p. 28).

Hoping is also a means of coping; and perhaps one of

the most important elements to promote in clients. Without hope, despair prevails.

Coping mechanisms (also referred to as techniques, responses, strategies, skills, resources and behaviors) developed by the sick person are a means to minimize the problems and/or concerns encountered in the day to day life with malignancy and thereby, hopefully, facilitate adoption to cancer's metastatic state.

Worden (1981) has identified four key ingredients of good coping:

1. Optimism - expectation of positive change.
2. Practicality - options and alternatives are seldom completely exhausted.
3. Flexibility - strategies change to reflect the changing nature of perceived problems.
4. Resourcefulness - ability to call upon additional information and support from others to strengthen how well one copes.

It has been suggested by Weisman and Worden in their article concerning the existential plight in cancer (1977), that people who do not suppress their needs and can accept support from others, tend to live longer than those who are pessimistic and apathetic. The perceived feeling of support and comfort can strengthen the feeling of control of the situation and thereby increases self-esteem.

The clinician is guided by the belief that by maximizing the cancer patient's sense of personal

control a higher experienced quality of life, particularly that component of quality known as psychological well being is achieved (Fiore, 1979).

Aggressive programs conducted by nurses, physicians, social workers and other health care workers are directed toward the service of meeting the support needs and symptom management of late stage cancer patients (Caplan, 1974; Cobb, 1976; Murawski, Penman, & Schmidt, 1978). The American Cancer Society originated the "I Can Cope" program - a series of self-help seminars presented by health care professionals in affiliation with many community hospitals.

Pruyn (1983) has provided a model for coping with the stress related to cancer and also offers means to dilute the problem of excessive stress that accompanies this multiple systems disease. Her means to reduce or solve stress are aimed at uncertainty, negative feelings, loss of control, and threat to self-esteem.

Informational needs are ongoing as disease progresses. The ability to step forward and seek information has been described as one of the most universal forms of coping (Cohen & Lazarus, 1979). Derdarian (1987) in her review of the literature concerning information/learning needs of those with cancer, has considered the following categories:

1. Disease - concerns about diagnosis, tests, treatments, and prognosis.
2. Personal - concerns about physical well-being,

job/career, psychological well-being and plans/goals.

3. Family - concerns about spouse or significant other, children, parent, siblings.

4. Social concerns - job/career relationships and leisure relationship.

She defines "concern" as a perceived harm or threat; "threat" as the perceived potential harm; and "harm" as the perceived existing damage, disruption, discontinuity, loss, malfunction and discomfort occurring in the client's physical, personal, family, and social life.

The two areas most covered in the cancer/psycho-social literature are locus of control and coping/adaptation. There is a continuing need to teach our clients how to both give and accept social support on both a formal and informal basis and to mobilize a personal network early in the disease process so that it can work for them later as their condition worsens.

The effort manifested by clients over learning more about their disease, exerting their rights in decision making and establishing social networks appears to be greatly influenced by their health locus of control. Health locus of control is described by Ingle, Burish and Wallston (1984) as a generalized expectancy that develops over time regarding one's beliefs about who or what controls his/her health. Health "internals" are those who believe that one is well or sick because of his/her own behavior while health

"externals" believe that luck, fate, chance or powerful others determine his or her state of health. Health locus of control experts suggest that internals have more advantage in responding to threatening illness or illness events. The same authors identify those people known as repressors vs. sensitizers. Repressors are described as those who exhibit avoidance behaviors and have a tendency to deny that anything is wrong. They give physiological evidence of anxiety while denying anxiety. Example: A professional business man with perspiration and trembling hesitancy attempts to follow the reinforcement step by step written directions provided for home use in changing of his colostomy bag. Sensitizers on the other hand attempt to reduce anxiety by approaching or controlling the stimulus. They tend to be excessive worriers and are more anxious and introverted than repressors.

While many patients with cancer can cope with their disease and the effects of treatment, there are those who are not able to overcome their vulnerability which varies in intensity and duration. Weisman (1979) states that the patient's vulnerability is an index of the distress experienced. It may range from feelings of helplessness to resentment, from anxiety to loneliness or somewhere in between. He identifies the following "vulnerability factor" as denial, annihilation or existential despair, alienation, destructive dysphoria characterized by anger,

disappointment, feelings of being misled or victimized. The best indicator of vulnerability is the number of symptoms the person has, especially systemic manifestations such as weight loss, insomnia and fatigue.

Valentine (1986) reports that in a 1979 national survey by Yankelovitch et al., 60% of the adults polled believed that being healthy required that individual take an active part in health care. Forty-six percent of respondents recently changed their life style to promote better health while 30% reported it took too much discipline.

The behavior changes necessary to reduce risks and improve health status are interwoven with personal values, knowledge and economics. Because of this complex situation, health education as a singular intervention is inadequate (p. 201).

The following review will include those approaches of psychotherapy as the Psychoanalytic, Cognitive (Crisis Intervention), Humanistic, and Behavioristic models. Inclusive of these interventions will be those generally considered to be unproven methods i.e., imagery/self hypnosis, relaxation techniques, therapeutic touch and biofeedback.

CHAPTER III

CONVENTIONAL METHODS OF APPROACH

Psychoanalysis

The literature is replete and ill defined on the topic of psychoanalysis as a treatment approach for the patient with cancer. Few references have been available concerning classic psychoanalysis with cancer patients. Psychiatrists have been consulted to evaluate and treat hospitalized cancer patients when: 1) the client has a past history of psychiatric problems and treatment, 2) staff and/or client relate a depression and suicidal ideation by the client, or when 3) the client exhibits unusual and/or disruptive behavior. Dr. Jimmie Holland at the Sloan-Kettering Cancer Center in New York states that "although everyone experiences some sadness and grieving about being ill, this is not depression. She estimates that true depression occurs in only a small percentage of cancer patients but suggests that when it occurs, it should be vigorously treated by psychiatric intervention, including psychotherapy and often antidepressant medication.

Cancer patients who are at highest risk for developing depression are those with inadequately controlled pain; a more deteriorated physical state; advanced stages of disease, particularly pancreatic cancer, and a history

of prior depression or psychiatric illness (Holland, 1987, p. 367).

A depressed patient will usually experience some or all of the following symptoms:

Presence of dysphoric mood (sadness, anxiety, irritability)

Feelings of hopelessness and helplessness

Loss of self-esteem

Crying

Presence of a sleep disorder

Decreased sexual drive

Loss of ability to think or concentrate

Loss of interest in usual activities

Uncontrolled fear of the future

Any severe or long standing symptoms need to be evaluated and for a greater benefit for the patient, treated with a combination medication with ongoing psychotherapy.

Since anxiety and depression may heighten the perception of pain, antianxiety and antidepressant drugs can enhance the effects of analgesics. Dr. Holland further advocates that persons "with psychiatric symptoms of severe depression or anxiety should be referred to a psychiatrist, preferably one who is familiar with the problems of cancer" (American Cancer Society publication).

Several studies published in the American Journal of Psychiatry have explored depression as it relates to specific cancers as those of the lung, pancreas, stomach and

gynecologic cancers as well as treatment by radiation therapy (Evans et al., 1986; Forester et al., 1985; Holland et al., 1986).

Holland et al. studied 107 patients with advanced pancreatic cancer and 111 patients with advanced gastric cancer. The patients were stratified by key medical/sociodemographic variables and assessed with the Profile of Mood States before beginning chemotherapy. The results of the study support the observation that certain cancers can be expected to be accompanied by depression. The depression experienced by these patients is thought to be related to the increase in neuropeptides in the G.I. tract and brain and an immunologic interference with the activity of serotonin.

Evans et al. who studied depression accompanying gynecological cancer states:

It is of interest that none of the patients with major depression exhibited melancholic or psychotic features. Furthermore, suicidal ideation was rare and none of the patients was considered an imminent suicide risk. These findings are congruent with those of Bukberg and associates (1984) who suggest that there is a continuum of depressive states and that the depression seen in hospitalized cancer patients differs from that seen in psychiatric inpatients, as first suggested by Plumb and Holland (1977) (p. 451).

Psychotherapeutic intervention must always begin where the patient is at the time. That is, intervention will vary depending on the patient's place in the course of the disease, the course and method of treatment and on the timing of when the patient/client and therapist come

together.

It is imperative that the patient first be worked up medically for a definitive diagnosis to determine if his behavior might in any way be related to some reversible abnormality in laboratory studies or possibly due to neurological invasion by the disease process. Analgesics, steroids and chemotherapy agents are known to induce states of confusion and delirium. Personal experience, lacking documented numerical data with cancer patients who exhibit unusual behaviors, has revealed that more than half of the clients who have been elected by the staff for psychiatric consult have had elevated enzyme or mineral values and/or metastatic extension to the brain. Dr. Holland has estimated that "about 20% of hospitalized patients have significant emotional distress and should be evaluated." She feels that early determination of which individuals will probably not cope well is very important and states they are easily identified by earlier difficulties in handling crisis in their lives. "A patient who possesses a genuinely cohesive self at the time of illness has the best prospect for avoiding psychological disarray" (Muslin, 1984, p. 109).

Abramson and Sackheim (1977) have suggested that depressed individuals may be characterized by the inability to discriminate controllable from uncontrollable situation. A feeling of helplessness prevails that vacillates with guilt. Self talk moves from "I am not responsible for my

fate to I am responsible for my fate." "This vacillation and uncertainty is viewed as exacerbating and perhaps even creating the depressive state. Failure to assign a stable attribution of controllability to an undesirable event is maladaptive" (Sulls & Mullen, 1981, p. 33).

There are patients who need a self object bond to regain cohesion, mainly in the direction of seeking expressions of confirmation of their worth, described by Muslin (1984) as "the mirroring self object transference." He feels that these needs change in relation to the state of their illness from the need for occasional reminders of their value to intense expressions of need during a crisis. These self/self object patterns, whether mirroring or idealized, are not static but vacillate as reflections of the need for certitude and to know that he will not be abandoned or considered of little worth.

Outpatient cancer clients, who recognize an emotional difficulty in themselves often seek counseling services on their own to help them deal with the many issues confronting them. Others are referred by family, friends, clergy, or health-care professionals. There are some probabilities that Renneker (1981) identifies that psychiatrists need to be aware of in the treating of cancer clients - hopeless, despairing, despondent, and desperate, depending upon the varying degrees of depressive states.

As in individual psychotherapy with other patients, individual psychotherapy with the adult cancer patient

must closely adhere to the patient's defense mechanisms. However, the management of, and therapeutic interaction around, the cancer patient's defenses must be approached with caution. It must be understood, at the onset, that the crisis of cancer generates 'primitive and primordial' fears as described by Pattison (1974). No one could live without psychological and/or psychophysiological decompensation in the face of such fears without powerful defense mechanisms to keep such threatening emotional fantasies in check. The psychotherapist with the non-cancer patient often may interpret the patient's defenses in order to reach deeper, more conflicting material. In psychotherapy with the cancer patient, however, the therapist does not want to interpret, and thereby diminish or sidestep, the patient's defenses. The defenses are present for the purpose of the patient's emotional survival, and this must be respected and understood as a sine qua non of this type of therapy (Wellisch, p. 224 in Prokop & Bradley, 1981).

LeShan and Renneker agree that mobilization and actualization of the relatively dormant part of the self identity as the "secret self" is fundamental in the psychotherapy of most cancer patients. Most patients undergoing medical-surgical cancer therapies are in a state of helpless dependency on others. The only thing standing between them and hopelessness is objective helpfulness. The exception of course is the person with a powerful belief system in the actuality of God and His intervention.

Based on a past history of psychological consultation, some patients have been known to be unnecessarily medicated with psychotropic drugs which have in turn resulted in a worsening of their depressive syndromes (Wehr & Goodwin, 1987). This exemplifies the need for a multidisciplinary approach for cancer patients due to their multisystem involvement. Use of tricyclics must be done with caution,

especially with bipolar patients where mania may occur. Central side effects of this classification of drugs are feelings of drowsiness and fatigue followed by later signs of mental stimulation. A noteworthy significant adverse reaction to this class of drugs is bone marrow suppression which could be an added problem to a patient with existing low blood counts.

Psychotherapy is directed toward maximal life enhancement with the understanding that even death and the dying process are developmental stages of life adjustment (Garfield, 1978). There are some psychiatrists who when consulted to become re-involved with a former client now with cancer, display great reluctance to do so. Renneker, in describing a project with cancer clients at the Chicago Institute for Psychoanalysis, states that "only 13 of the 235 (psychiatrists) attempted to help 21 patients fight their cancer psychologically. This strongly suggests that the remaining 222 psychiatrists were unaware of the possibility, uninformed as how to proceed therapeutically, emotionally unwilling, or did not believe that it represented a genuine alternative" (p. 133). He describes this type of cancer therapy as "relatively long-term, emotionally traumatic, replete with unexpected intervening variables and tends to physically deplete and exhaust the patient" (p. 137).

"Fighting and coping are continuing factors in the

psychotherapy of a cancer patient and ... fighting is the predominant mode of coping" (Renneker in Goldberg, 1981, p. 135). Since adjusting to cancer is long-term, ongoing and periodic, the problem is acutely, chronically there as long as the cancer is and for years thereafter. The problems cannot be shaken free like rain water from an umbrella; rather, they permeate and surface in a cyclic style.

The male cancer patient may have inherent difficulties in confronting his illness based on the traditional male stereotype. Men may show aggressive acting-out behavior with an inability to communicate with others and a refusal to participate in counseling. Liss-Levinson (1982) describes a certain "emotional constipation" with men and an inability to share with others on an emotional level. While most men appear to be in touch with some range of feelings, they have difficulty in self-disclosures with others. For many males, a common response to a challenge or threat to their sex role has been through physical or verbal violence. With the male cancer patient, the problem is finding the "opponent" to fight and overcome. There is no real direct way for the cancer patient to strike out at the disease and anger may be displaced onto staff or significant others.

The Objective - The Task - The Tools

The literature has noted that cancer and the usual concomitant medical treatments are regressive experiences accompanied by dependence. Cancer patients frequently feel

helpless and without the internal resources to reverse the progression of the disease. The objective of analysis is to bring the person from a state of dependence to one of independence and self-nurturing. The initial task is to facilitate expression. While the "story telling" part of catharsis is not curative, it is a necessary step to remove emotional blocks that interfere with verbalization. The tools used by the analyst to bring about this state are those of transference and resistance analysis.

Typically the analyst becomes the primary transference object onto which fantasies, ideas, and feelings are projected. The establishment of a negative transference is recommended in the treatment of neurotic and psychotic patients in order to aid the patient in the free verbalization of all thoughts and feelings - negative as well as positive (Goldberg, 1981, p. 194).

Searles (in Goldberg, 1981) specifies the role that the psychoanalyst can play in the exploration of the unconscious of the cancer patient. He denounces the idea that cancer is potentially curable through psychological means. This is in contrast to Goldberg who has a chapter devoted to "curing cancer psychoanalytically." Searles contends that if a therapist proports to cure cancer through psychological means, then the same person must deem themselves capable of contributing to the origination of the cancer. He admits that his experiences in having cancer patients in therapy are few, and suggests that exploration of what the cancer represents unconsciously to the patient is one avenue of analysis. In contrast with Wellisch, Searles upholds the

idea that in a standard psychoanalytic fashion, both therapist and client can discover unconscious defensive functions where the facts of the presence of cancer or the client's preoccupation with their disease, is effecting their psychological life.

Goldberg admits that the treatment of cancer patients differs in some respects from others involved in the analytic process and that the establishment of a prolonged negative transference early in treatment may be contraindicated. In addition, the slow process of analysis may be out of pace with the speed of the disease. During the time it takes to work through the negative transference, the patient may die never having experienced positive feelings.

Muslin also recognizes the limitations imposed in the cancer process.

In some cases, psychotherapy may result only in the establishment of basic self/self-object transferences in which the patient experiences an elevation of mood and enhancement of worth. However, depending on the patient's capacities, the patient and therapist may be able to enhance self-worth through the ordinary modes of psychotherapy - insight through interpretation (p. 120).

Goldberg notes that cancer patients can use their illness in a passive-aggressive way.

They can make demands that exceed the limits of human capacity to fulfill; they can be troublesome and quarrelsome and argue that nothing is ever done the way they want it. For some, the onset of the disease is a natural fulfillment of their already entrenched position in relationships. The disease may be experienced as a relief, because there is now concrete

evidence for rationalizing their mode of interaction. This attitude usually reflects an unconscious blaming of another person for the disease. The demands for care-taking are used as weapons of revenge (p. 193).

psychoanalysis can help this type of patient in their anal-sadistic power struggle, whom Goldberg likens to "the baby who defecates in his diapers at precisely the times that are most inconvenient for the mother" (p. 193).

The other side of the coin is the patient with what is described by Renneker and LeShan as the Pathological Niceness Syndrome (PNS). The expression of niceness becomes an automatic habit pattern. This type of patient is easier for the staff to deal with and their niceness is frequently reinforced and rewarded. Displays of anger or any negative emotions associated with displeasing people are avoided by the patient. Assertiveness and self-directed questions or actions are not behaviors used to meet their needs or wants. Niceness becomes a dominant way of coping with life. The emergent personality is compliant, submissive, passive, selfless and eager to please. Over time they learn to adjust to the continuous self-deprivation and denials. It is not uncommon to hear these patients say - "Oh, I don't mind," "It's ok" or "I don't care." Inside, all is not ok and they do indeed mind and care. Some people do break out of their niceness pattern but usually not without the help of a significant other person.

Assertiveness skills are taught to the patient by the analyst with the intent to help the patient in coming to

feel himself as being part of the process rather than the object of the process. Some clients need to be made aware that as consumers of medical treatment they have a right to object to what they feel is wrongful treatment. They will need help, however, in dealing with the resulting rejection by those whom they have come to rely on for medical help. It is because of such rebound rejection that cancer patients tend to quietly question their treatments without open expression. Such thinking may itself contribute to the lack of success of a treatment. Failure accompanied by an obligation to trust one's "helpers" may result in more failures and depression.

Whether the aim of psychotherapy is solution to a problem or professional support in coping with a normal emotional reaction to stress is generally not crucial to the outcome of the intervention. Ed Schneidman (1978), a noted Thanatologist points out the importance of remembering that: "The cancer patient is a living person facing new and bewildering life stresses...." He has stated that we cope with stresses of cancer and death as we have with other life stresses. Others, such as Viney (1984) disagree with such thinking and have noted that cancer is a stress unlike any other previously experienced since it effects multiple aspects of one's life and may lead to death. There are no mentors available who have experienced death, and the engulfment of incertitude coupled with other life stresses

may lead at times to temporary psychosis requiring intervention.

The use of the MMPI has been used frequently by researchers studying depression with cancer patients. Caution is needed when using this and other scales that report somatic complaints since they tend to reflect the actual byproducts of physical illness and not those of true psychological depression. Unlike the MMPI, the Dempsey Depression Scale does not reflect items that deal with somatic complaints and is endorsed by Freidenbergs et al. as a more reliable tool.

When usual life responsibilities prevail and the hopelessness and helplessness of a progressive cancer become overwhelming, thoughts of suicide may seem the best alternative to the person with monumental problems.

Cancer and Suicide

Many aspects of an advanced cancer patient's life can be depressive. When emotional boosters from others no longer seem helpful and when hope no longer exists, suicide may be contemplated as a means to escape overwhelming pain and despair. Suicide may be viewed as a means to control life which has been medically directed by others. Pain and prolonged suffering may make one feel exhausted and defeated. Since depression is present in almost all patients with terminal illness at least at some point, the possibility of a suicide attempt is present.

Leigh (1974) relates that while there is a large body of literature recently accumulated concerning the dying patient, there are few case reports describing psychotherapy of patients with terminal cancer who attempt suicide. He provides such a case report of a cancer/suicide patient who was unable to ventilate her sad feelings to either her doctor or family. The suicide attempt opened a channel of communication for her and resulted in a trusting relationship. He states that "the analysis of the serious illness should be to provide hope through a psychological sense of control over the illness and its psychological meaning" (p. 181).

Not all suicide attempts are a cry for help. There are those who truly feel that suicide would be the most rational action to take. Since others are unable to help him, he may reason that he will therefore help himself by taking his life in his own hands.

Siegel and Tuckel (1984), two sociologists from New York, reviewed this area of rational suicide. They found that the evidence which had been adduced suggested that the occurrence of suicide is not greater among individuals with advanced cancer than among the general population. The various organized groups which make up the Rational Suicide Movement have lost influence with the growing number of Hospices available to care for and comfort the terminally ill client. However, it may never be known how many traffic

or other accidents may actually be suicide attempts.

Fox et al. (1982) published a lengthy longitudinal study of suicide rates among cancer patients in the state of Connecticut between 1940-1943. They hypothesized beforehand that suicide rates would occur more frequently soon after diagnosis. They conclude that both hypotheses were supported for males, and neither for females.

Men with past cancer diagnosis commit suicide more often than do age-equated men in the population, while women do not; and risk of suicide in men is greatest soon after diagnosis, becoming less with time, whereas this is not true among women (p. 96).

Since this study encompassed a time frame prior to the advent of many of the cancer diagnostic tools and newer treatment measures, a duplicate updated study would seem in order.

Personal experience reveals that there are some physicians, who upon concluding that some of their patients had terminated their own lives by evidence of empty medicine bottles, are reluctant to provide pain relief medication for home use. Thus, future patients are rehospitalized when the pain becomes unbearable, medicated for a few weeks and sent home again. This cycle repeats itself until death.

Hansen and McAleir (1983) did an indepth review of the literature that revealed that in our culture suicide is viewed as the irrational act of a mentally disturbed person and must be prevented in the person's best interest. Their study was with health care professionals. Using the

Templer's Death Anxiety Scale as their instrument, they conclude that when health care professionals believed the patient had cancer or other terminal illness, they rated the patient as more psychologically stable and more likely to make a successful attempt. They also were more likely to "employ prevention strategies that left ultimate responsibility for the decision with the patient" (p. 245). The study's conclusions also support the view that practitioners who experienced the highest level of anxiety surrounding death-related topics rated the patient as less rational and more likely to make a successful suicide attempt than did practitioners with lower levels of death anxiety. Thus "high anxiety practitioners were more likely to employ prevention strategies that require the practitioner to take control of the situation and assume responsibility for the patient" (p. 246).

There are those prominent oncotherapists i.e., Holland (1973) and Weisman (1979) whose impressionistic data support the view that suicide among hospitalized cancer patients is extremely low. Weisman relates that about 10% of newly diagnosed cancer patients admit to suicidal thoughts. He asserts that "while suicidal people are generally hopeless... not all hopeless people commit suicide." He compares hopelessness to anger and that not all angry or outraged people commit murder. Weisman has provided a profile of those persons most at risk for suicide.

Table 5

High-Risk Patient Profile (Those Experiencing the Most Distress)

Personality:	Low ego strength, high anxiety (MMPI) Pessimistic
Past history:	Marital problems, if married Living alone Lower socioeconomic status Alcohol abuse Infrequent church attendance Multiproblem family of origin Psychiatric treatment Suicidal ideation at times
Physical status:	Advanced staging More reported symptoms
Plight:	More problems of all types Expects and receives little help Sees physicians as less helpful or concerned
Performance:	Try to forget; put it out of your mind (suppression and passivity) Submit to the inevitable; fatalism (passive acceptance) Withdraw into isolation; get away (disengagement/isolation/withdrawal) Blame someone or something (externalize/ project) Blame yourself; sacrifice or atone (feels more like giving up/poorer resolutions)

(Weisman, 1979, Table 4, p. 68). Permission for reprint granted by publisher

Maxwell (1980) has contributed to the cancer/suicide literature. She notes that few actual studies have been done, mostly in Europe, and what information is available is contradictory. She reviews the Farberow et al. study of suicide among cancer patients in Los Angeles in 1963, in which 32 cancer/suicide victims were compared with a control group of 32 cancer/non-suicide deaths. A psychological autopsy was done by a multidisciplinary research group who searched for clues that might indicate suicide tendencies. Among their findings were the following: Depression alone did not distinguish potential suicide. Suicide occurred only in patients who were alert and oriented. The decision to commit suicide and not physical strength was an important variable, with two very debilitated patients having planned and mastered the event. In addition, the suicide group tended to have more life stresses in addition to their illness. One emerging pattern seemed to be that generally those who committed suicide were use to taking charge of their life and had an active need to control their environment and an active interest in directing and controlling the cancer situation. They tended to refuse some treatments and request the initiation of others. Generally, they seemed to be an assertive group of people.

Farberow and Schneidman have co-authored a book, The Cry for Help (1961) that could be used for further reference. Some other studies done in the 1960's suggest

that the young rarely communicate their intentions, while older people frequently do.

Ruben's clinical criteria (1979) reflect that of Weisman (1979). To ward off any feelings of hopeless or rejection, Maxwell suggests that nurses can increase the time spent with depressed cancer patients and help to decrease the individual's feelings of isolation, and bolster their self-esteem. She advocates allowing the patient to externalize their anger and rage, thus releasing depression. The concept of "loss" needs to be explored with a focus on their individual situation. Discussion of guilt feelings related to unworthiness and punishment by cancer can also be explored. If trained in the assessment skills, nurses have a unique opportunity to assess coping abilities, emotional strengths and weaknesses. Measuring the social support available to the vulnerable cancer patient seems particularly important. Maxwell provides six specific questions that are frequently asked by mental health specialists in situations where suicide is suspected (p. 37).

1. How would you describe your mood? Have you been feeling sad or depressed? (However, it is the author's experience that many cancer patients do not relate to the word "depressed" as descriptive of these feelings.) Do you find yourself crying easily without apparent reason, or experiencing pronounced mood swings? It may be helpful to

ask the patient to rate his mood on a scale of 1 to 10; 1 being the worse he has ever felt, and 10 the best.

2. Ask about the physical signs and symptoms of depression. Have you had a change in your appetite, in your sleeping pattern, in your interest in sex? Be alert for either "much more" or "much less than usual" in the patient's responses for early morning awakening, waking up tired in the morning, weight loss, and a decreased interest in sex. The difficulty of sorting out which of these symptoms may be related to the disease or treatment and which relate to depression is acknowledged. However, the nurse usually knows the patient well enough to have some clues as to which causes are operative.

3. How do you feel about your situation? Would words like discouraged, helpless, hopeless, being punished, a bad person, guilty apply to you?

4. Do you find yourself withdrawing from things that used to interest you, or from life in general? Have you lost interest in your hobbies, past activities, your personal appearance?

5. Do you feel that your family and friends are helping you? Do you feel cut off from your family? Do you feel empty inside, deserted, totally alone?

6. Are you thinking of ending your life? Do you have a plan? Have you bought the gun, secured the pills, or in general prepared to carry out the act?

Suicide remains a multifaceted problem involving philosophical, theological and ethical dilemmas for health care providers in their attempt to increase the quality of life for their clients.

Humanistic - Patient-Centered

Those individuals most likely to fall into the realm of humanistic counselors include Elizabeth Kubler-Ross, Lawrence Le Shan, Feigenberg, and Rogers.

In an earlier review of the literature, McKittrick (1982), reviews Feigenberg's work. Feigenberg stresses that his approach is different from traditional counseling, psychotherapy in several respects. First, he sees that the client not the counselor is the one who decides what problems will be discussed and when the discussion will occur. During the various terminal phases of illness, the client is typically faced with a series of unanticipated problems such as new or old symptoms occurring or friends and relatives close to the client reacting to his situation. Feigenberg is of the opinion that the phases of the terminal progression drain the client of both physiological and psychological strength, so that the person may not have the energy to devote to psychotherapy that a physically healthy individual would.

"Perhaps the most significant difference between this approach and classic counseling is in the aim of treatment." The central aim of classic counseling says Feigenberg, is in

the removal of the psychic symptoms and problems, through insight and subsequent working on the symptoms and problems. In contrast, a primary aim of the patient-centered treatment is directed toward meeting clients' needs to develop their individuality to the greatest possible extent. Another aim is to help the client relinquish emotional ties.

Many counseling theories advocate using the families as a support resource for clients. Feigenberg recommends severing contact between the counselor and families at the beginning of the counseling process. His counseling deals mainly with those in the final stages of terminality and so he theorizes that most of the pain of dying involves the necessity of breaking emotional ties with loved ones.

With Feigenberg, clients are expected to set the direction and pace of counseling to meet their specific needs in their own way. The expenditure of energy involved in this approach would seem to be greater than when more direction is given by the counselor. It is ironic that while Feigenberg recognizes the extent of psychic drain which accompanies the extension of illness, he has advocated a treatment that requires so much effort on the part of his clients and without support of family involvement. McKittrick points out that Feigenberg's approach is intended for terminally ill cancer patients who most likely have many of their needs met by hospital staff and who can afford to direct their energy inward. It would not seem to be an

appropriate approach for those persons in earlier phases of terminality who remain functional to a moderate degree and have an accompanying responsibility for most phases of their life.

Cognitive

Crisis Intervention

In Caplan's 1969 text, Principles of Preventive Psychiatry, he describes crisis as "when a person faces an obstacle to important life goals that is, for a time, insurmountable through the customary methods of problem solving." While crisis is an emotional condition, it reduces the individual's cognitive function (Taplin, 1971). Crisis as described by Price and Szczesny (1985) can be divided into two main types: either situational or maturational. Situational crises are the result of an occurrence beyond the individual's control. The diagnosis of cancer especially if sudden, unexpected or already in advanced stages can create a temporary emotional disruption or situational crisis for the person. The feeling of total helplessness with the knowledge of necessary treatments and the personal confrontation with a nearness to death, may be exhibited as depression, anger, fear, isolation and loneliness. Both situational and maturational crises are potential events. Some crises can be predicted and prepared for as a person progresses through the life cycle.

Cancer and its related problems may present as either

an acute or chronic situational crisis. This is more true today than in past years because advanced technology of medical treatments and extended life expectancy heightens the expectation of loss. When the situational crisis of cancer or related problems coincide with transitional periods in the person's life, the impact and intensity of the crisis may be understandably greater. Plans and future goals are tentative, while finances may become more problematic. The uncertainty of remission and changes in treatment make a state of homeostasis seem almost impossible.

A basic premise of crisis theory is that resolution and psychological equilibrium takes place in a short time, generally within six to eight weeks. In the research done by Gottesman and Lewis (1982) on Differences in Crisis Reactions Among Cancer and Surgery Patients, the results confirmed their earlier 1979 study that contradicts that much held assumption that crisis lasts from six to eight weeks. In their later study, none of the feelings and reactions associated with crisis diminished over the 15-week observation period. In the 1979 study, crisis reactions never reached equilibrium and were still worsening eight weeks after onset - the time at which theory calls for an end to crisis. Thus it would seem that crises are indeed of limited duration but that duration is far longer that crisis theorists have believed it to be. In addition, the same

work by Gottesman and Lewis (1982) report that crisis can differ in both type and magnitude. While both the cancer and surgery groups they studied reported significantly higher levels of general crisis behavior and depression than the normal control group, only the cancer group reported significantly high levels of helplessness. Thus, the results of their study seem to indicate that the crisis of cancer appears to produce a greater sense of helplessness.

There is little doubt that the realization of having a terminal metastatic illness naturally gives rise to an emotional crisis with negative emotions and defensive behaviors, among these, anxiety, grief, depression, anger, withdrawal and denial of the threatening event.

While Elizabeth Kubler-Ross is considered a Humanist some of her material is applicable to the cancer patient in crisis. The five phases she has formulated suggest that terminally ill and dying patients' emotional experience may come together and be "jellied" then "fluid" repeatedly in rapid succession during a time of crisis: "not me" (denial), "Why me" (anger), "Yes, me but" (bargaining for time), and "Yes, me" (depression). During the period of crisis resolution, the patient may begin to verbalize "Yes, me - however...."

Crisis for cancer patients may occur at certain key points of their illness. Crisis is frequently experienced at the time of diagnosis. Case studies of such examples are

presented by Peterson (1984). One such case of Mr. D., whose mental state was normal at the time of diagnosis, deteriorated rapidly over 24 hours after being told of his bladder cancer and that surgery would be needed to remove the bladder and prostate with an urinary diversion to his abdomen. Since certain autonomic nerves would be cut, he would be left impotent. His behavior became agitated and inappropriate, escalating to the point of maladaptive behavior when he became violent, and psychiatric admission was required. When the patient was given the control he needed, that of being allowed to express his emotions and to make the decision not to have surgery, his behavior modified and he rapidly recovered emotionally within 10 days and returned home to live in a way he chose. "I would rather die with my body the way it is ... I don't want to lose my manhood." The patient chose to die with multiple metastasis versus a 50% chance of having no recurrence at all of his cancer had he accepted surgery. Having made such a decision he felt that he rather than others were in control of his life.

In addition to the time of initial diagnosis, there are other times when the cancer patient may experience crisis. Included are when surgical procedures or painful treatments are to be performed; when symptoms re-occur or increase in intensity; and at times of rehospitalization.

It is often difficult for health care personnel

including physicians, to accept the normal, healthy expression of emotions. Denial, for example, may be a temporary response which allows the patient to assimilate information at a tolerable rate. "The immediate alternative to denial could ... overwhelm the patient and throw him in a state of crisis" (Crary, 1974, p. 37).

While intervention for crisis is time limited, it is also problem focused and oriented toward attainment of specific situationally appropriate goals. The phases for crisis intervention are the same as those used for any problem solving process - assessment, planning, intervention, integration or evaluation and resolution.

It is generally believed that intervention is best done during the initial stages of the stressful situation. The literature suggests that assessment of the patient's emotional strengths and coping ability should focus on the meaning of the unique stressful situation at hand as well as what meaning the cancer has for them, previous stressful experiences, usual methods of coping and any support systems presently available.

Capone et al. (1979) categorize the intervention process in terms of four very broad categories: (1) shaping of reality-based expectations, (2) facilitating attainment with processing of appropriate information, (3) encouraging patients to take responsibility for resolving their emotional distress, and (4) helping patients to reintegrate

the concept of being a whole and functioning person.

Krause (1982) seems to have elaborated and clarified the above categories when she describes goals of intervention as to

(1) relieve acute anxiety, confusion, and hopelessness; (2) restore the patient's functioning to a maximum level; (3) assist the individual to explore alternative solutions for the problems; (4) understand the extent to which past beliefs/expectations play a role in the present reaction to illness; and (5) develop new attitude behaviors and coping techniques that may be effective in the future (p. 97).

Crary (1974) suggests several interpersonal and behavioral techniques to help patients cope with a cancer-related emotional crisis that include: keep the future open, focus on and provide what the patient can still enjoy; find alternative activities which he can perform, or alternative ways to perform gratifying activities (including sexual functioning); reward the patient's healthy adaptive behavior; concentrate on symptoms which can be treated; avoid self-fulfilling prophecies; and involve others in the treatment team (p. 38).

Behavior based on expectation is often self-fulfilling; therefore, the therapist's active direction early in the intervention process can have long-term effects. The process of clarifying and reshaping existing expectations, as well as setting new ones, requires repetition and frequent reinforcement to enable patients to internalize them (Capone et al., 1979, p. 603).

Examples are provided concerning self-fulfilling messages i.e., When a patient communicates a message, "I'll never have sexual activity again," the mate tends to accept

that message and may no longer initiate sexual contact. With those persons whose expectations are overly optimistic, maladaptive or unrealistic, the therapist needs to exercise skill, sensitivity, and patience in reshaping. Especially important is helping the person to identify valued functions that will not have to be given up in addition to some that may need to be postponed or abandoned. Equally important is that the therapist encourage or provide available options and contracting to meet appropriate behavioral goals. The therapist/counselor needs to encourage patients to ask adaptive questions and to become active in personal problem solving and decision making. For some, this may be a totally new behavior expectation, especially if they have relied heavily on others in the past and have been caught up in a learned helplessness pattern. They will need to be helped to see that parts of their environment can be controlled by them and that there are some at least potential solutions to their problems.

The integration phase described by Capone et al. emphasizes that the techniques used during crisis intervention support the view that patients are whole individuals rather than "sick parts." Patients may feel fragmented and have low self-esteem. Much reinforcement may be required to encourage this wholeness type of thinking. It is also pointed out that physical contact i.e., touching the person's hand or arm can be useful in counteracting

feelings of fragmentation and depersonalization.

During the resolution phase of crisis intervention, the patient and therapist collaborate on making realistic plans for the future and assess the need for follow-up treatment.

The goals established by Krause (1982) provide a flexible framework allowing for variations in counseling styles and techniques. It is advocated in the literature that the therapist be skilled in rapid, accurate assessment of the patient's emotional status; be able to recognize both adaptive and maladaptive coping mechanisms and in direct relation to the information assessed, initiate effective intervention. It is imperative that the therapist/counselor establishes a strong commitment to the client/patient and be a strong advocate for the person during this highly vulnerable period of time, however long it may be.

If the cancer patient is hospitalized at the times of a crisis situation, the resulting emotions of panic, fear, hostility, etc. may be held inward. Hospitalized patients often find themselves in an environment that rewards cooperation and punishes hostility. Klagsbrun (1983) has referred to this withholding of emotions as a "black out zone," a state she describes in which the patient interacts with others but fails to communicate deeply or make meaningful efforts to share feelings and adjust to the implications of their crisis state. She advocates that it is at this point, before maladaptive coping styles have

become entrenched, that psychosocial intervention may be most valuable. Such intervention, however, presupposes the availability of therapist/counselor at the opportune time.

Not all cancer patients are capable of verbalization with a counselor/therapist. Those with head/neck/throat or respiratory cancers may make verbal communication virtually impossible. Presupposing that the individual is literate and with adequate eyesight, the alternative method of writing as a means of communicating with the therapist may be a possibility. The therapist in this case may need to be more verbal, pick up on clues and expand them, allowing the patient to concur or disagree with what is voiced. Patients with occlusive dressings or disfiguring facial/neck scars, may make the task of zeroing in on non-verbal facial clues more difficult.

Kaplan and Hurley (1979) note that the compounding of multiple losses may evolve into a crisis for the person. Such losses may include loss of speech and pleasure of conversation; loss of oral gratification if the person needs to be fed by tube; loss of accustomed activities of daily living; loss of an intact body; and loss of independence. The resulting depression is a normal reaction. These people need to be appraised as to what they can realistically hope to change and what cannot be changed. Introducing them to others like them who have had a healthy adaptation may prove beneficial. It is important to maintain a balance between

ventilation of feelings and practical discussion of current reality and future goals.

The social work and especially the nursing literature have provided more depth, clarity and concreteness on how to intervene with cancer patients experiencing crisis. Social work studies frequently have also involved the family unit. Some of the recent nursing literature has provided very instructive approaches to assessment and intervention and have brought together in a workable format, the work done by other disciplines. Rickel (1987) is just such an example. She utilizes the visual/auditory principles of teaching/learning and has referred to the person's problems as "manageable mountains." For the patient in crisis, the top of the mountain may seem to be engulfed by clouds of uncertainty. Helping the person to divide the mountain into levels or parts and then dealing with each part, may help to establish some control to the situation. Visualizing by drawing pictures with the patient of their problem situation can stabilize the whirled thinking that occurs in crisis. An example might be to draw a pyramid divided into five or six levels with the problem of greatest priority being at the bottom and the problems with more solvable solutions at the top. Using this concept along with the person's available tools of support systems, personal strengths and usual coping mechanisms, the mountain can be gradually reduced. Rickel also suggests building a ladder of four

"H's": hope, helpfulness, harmony, and humor.

The top rung of the ladder is hope, the necessary ingredient to face everyday realities. The next rung is helpfulness. Since one of the feelings during crisis is helplessness, the goal of intervention is to overcome the feeling with a positive action. The next run would be harmony, developed through trust in the relationship. The last rung is humor. Laughter can provide a release of tension and anxiety and can accomplish reverses to harmful physiological changes caused by a buildup of stress. It also provides a means for individual feelings and concerns to be shared.

Rickel (1987) is in agreement with Kaplan and Hurley (1979) who assess that the person in crisis may need to be appraised as to what they can realistically hope to change. She advocates the use of lists created by both patient and therapist concerning what each see as problems, strengths, supports, things that can be changed soon, things able to be changed in time and things that cannot be changed. The counselor/therapist will also need to assess themselves as helpers. They will need to look at those situations which are life threatening i.e., suicide and advancing disease; areas where they are capable of giving assistance; and areas where they may need to rely on other resource persons for assistance with such things as financial problems.

Modern hospitals now generally provide single occupancy

rooms to cancer patients who are by their disease process, immune suppressed. This also allows greater privacy for the release of emotions and needed counseling sessions without disturbing an ill roommate. For some persons, the outlet of emotions and the sharing of feelings with another may create much anxiety in and of itself. Privacy and confidentiality are therefore paramount.

While the literature advocates counseling interventions at times of crisis, in reality, few institutions caring for cancer patients have the resources of trained personnel available for this type of caring. All too often, patients suffer these times in silence, not wanting to bother an already busy staff and/or feeling a sense of inappropriateness to having such a reaction well up within them. Contentment and quiescence are therefore not cultivated for many; physical tasks tend to take greater priority for a busy staff. The oncology nursing staff may not possess counseling skills but may play an important facilitative role by recognizing those behaviors which may warrant intervention by a counselor, pastoral care or social worker that could ease the patient's burden while hospitalized.

In reviewing the literature on crisis intervention with the cancer patient, it appears that the psychological and pastoral care literature tend toward the theoretical approach, while nursing and social work literature are more

definitive and explanatory in the presentation of materials.

Heinrich and Schag (1984) discuss limitations of the crisis model. They feel there are drawbacks to applying a crisis intervention model to a chronic illness like cancer. They emphasize that there is a time lapse between an event that may occur when the client is hospitalized and the actual feeling of realization of the event when they are back in their home environment. They believe that living day-to-day with cancer requires a more comprehensive ongoing evaluation as the client returns home and struggles with chemotherapy effects, fatigue, altered social and family roles, etc. It is proposed that a behavioral medicine approach is best suited to this task since it provides specific interventions for specific problems over a longer period of time. They imply early in the article that focusing on previous stressful experiences, usual methods of coping and support systems available to the client is somehow inappropriate for the multiple progression of problems encountered in day-to-day living for the client. However, they do lend support to the fact that such a model may be helpful at the time of a cancer diagnosis and the problems associated with hospitalization. They discredit their study by noting - "there is little empirical information on the type of problem experienced by cancer patients." Indeed the literature is replete with such information.

Crisis situations do occur once the client is discharged, however, he may realize he no longer has the convenience of a call light to summon assistance. For those persons feeling distressed and still motivated to reach out to others, cancer crisis hotlines exist in some of the larger cities of the United States. Seldom would one know about the availability of these without first contacting a hospital, library or American Cancer Society unit. In the Chicago area, the Cancer Call PAC (People Against Cancer) provides a 24 hour service for those feeling anguish and in need of talking about it.

Behavioral

Does the presence of disease and accompanying fatigue impair the ability of the patient to concentrate, remember, respond to interviewer's questions or complete questionnaires? Logic would dictate that this is quite possible; however, Barofsky disagrees.

It is generally agreed that neuropsychological complications of most types of cancer are minimal until the more terminal phases of the disease or unless the person has a specific type of displacement of a brain tumor (Barofsky in Prokop & Bradley, 1981, p. 59).

As with the cognitive and psychoanalytic approaches, behavioral therapy is an adjunct to the primary medical treatment for a more additive effect within the arena of holism.

The holistic model, which posits a relationship between carcinogenesis and the functional state of the whole organism allows for the possibility that psychological factors may contribute to impairment of homeostatic

controls (Greer, 1979, p. 83).

As stated elsewhere, cancer and its usual concomitant medical treatments, are regressive experiences accompanied by dependence. The prevailing helplessness may be translated into self talk that reflects "There is nothing I can do about it."

The goal of behavioral therapy is to help the person find certitude and control in at least some aspects of his illness situation. Unless the person can come to realize that they can do something to add to the help already being given, they would not be candidates for the behavioral approaches. Behavioral therapy presupposes the individual's interest and motivation to become involved in their own treatment. Orem's Self-Care Theory (revised in 1980) was designed for those in the nursing profession and developed mainly in the medical-surgical settings where patients are taught various procedures to facilitate their own management at home. Examples are procedures for ostomy care, wound management and use of infusion pumps. The ideal situation is one where the patient/client acknowledges a self-care deficit, recognizes a need for change and allows a service to be provided to compensate for the deficit. The client is actively motivated toward decision making and understands that the service contract terminates when the patient is able to assume care without outside assistance. This more cognitive-behavioral approach does not deal with any of the

deep seated feelings that might be involved in how they feel about self care. Rather, a procedure is taught and certain learned behaviors are expected.

Moore and Altmaier (1981) distinguish between cognitive and behavior and how one can affect the other. Cognitive treatment is a broad-based term which implies modifying a person's thoughts, attitudes, and beliefs. It is the assumption that inherent in cognitive therapy is that all human motives are cognitively directed because they are filtered or mediated through the perceptual system, which directs both the structure and dynamics of personality. Behavior is the acting on thoughts or beliefs and behavior change is achieved by altering the cognitive aspects of personality structure (p. 389).

We know that some adverse side effects of cancer therapies can be attributed to the pharmacologic properties of treatment while others appear to be conditioned or learned responses. An understanding of the theory of learned helplessness supersedes any discussion of the various behavioral approaches to psychological intervention with the cancer patient. The evolution of the theory of learned helplessness is reviewed by Stoner (1985) who examined its possible applicability to understanding some individuals' psychological adjustment to cancer. An attributional framework contends that an individual's blame for an uncontrollable event can be classified using a

dimension that distinguishes between two types of helplessness proposed: personal and universal helplessness.

Personally helpless individuals believe the event is controllable but that they do not have the skill to do so. Universally helpless individuals believe that neither they nor anyone else possess the ability to control" (Stoner, 1985, p. 32).

This dimension also addresses the locus of control in learned helplessness. The original theory by Seligman in 1967 identifies externals (those who attribute events to luck, chance, fate) as more prone to feeling helpless. However, since the revision of this theory by Abramson et al. (1978) it is now thought that internals are more prone to "personal" helplessness and externals are more prone to "universal" helplessness. The example given by Stoner is: internal/personal (I smoked, therefore I'm to blame for this cancer) and external/universals (My uncle smoked three packs a day and never got cancer - either you get it or you don't).

Blame placed on a stable or relatively permanent characteristic (cancer had ruined my life) is more detrimental than placing the blame on a variable or potentially changeable characteristic (if I could work, I would feel more worthwhile) (p. 32).

Assigning blame to a global dimension i.e., everyone treats me differently now, is said to have more far-reaching consequences than blaming a more specific dimension i.e., "my two closest friends feel uncomfortable talking about cancer."

A growing number of clinicians are beginning to realize

the role of both the pharmacologic properties of treatment and conditioned or learned responses of clients in choosing an approach that will be most beneficial. If the literature is any indication, it appears that more is being done in behavior therapy than the other approaches. The trend is to teach various behavioral relaxation techniques including hypnosis, guided imagery, progressive muscle relaxation, biofeedback and desensitization to reduce the conditioned side effects of cancer chemotherapy and control fatigue of radiation and chemotherapy. The choice of method depends upon availability and preference of the clinician. Prior to the initiation of any of the cognitive-behavioral methods, an assessment must be done to determine client readiness, locus of control and motivation to learn. It is important to emphasize that techniques are not taught alone but rather are in conjunction with either individual or group psychotherapy and always an adjunct to medical therapy.

Cancer patients generally tend to feel weak and fatigued, a state that becomes intensified with treatment protocols. Contrary to Barofsky, concentration powers may be diminished as well. Since practice is needed to develop and perfect the skills introduced by the therapist, some clinicians believe that a more active co-participation in care can be obtained in individual therapy. A branching out and applying of these methods to the other large arenas of one's life and promoting a general emotional self growth may

be a longitudinal goal. For some clients, the 1-1 contact, feeling of not being abandoned and the interest generated by a caring person may help to elevate an otherwise depressed mood.

Stress Inoculation

Moore and Altmaier (1981) recognized that constraints on staff time and sporadic treatment regimen scheduling made conventional psychotherapy difficult if not ineffective for the problems associated with side effects of chemotherapy drugs. In their research, stress inoculation techniques had never before been applied to the stress experienced by cancer patients. Their investigative project was to use stress inoculation training as a model of coping skills for nine cancer out-patients. They describe stress inoculation training as a "complex multifaceted training procedure" which teaches and implements coping skills and is essentially a process of behavior change including both cognitive and behavioral interventions. The three components of the program were education, rehearsal and application. Specific cognitive coping skills taught were (a) identification and monitoring of anxiety-arousing thoughts and beliefs regarding one's response to self statements, (b) creation of anxiety-reducing (coping) self-statements, and (c) alternative or substitution of coping self-statements for negative or catastrophic thoughts.

An assessment interview was conducted prior to

chemotherapy treatment, where the patients were asked to list all thoughts and images concerning the clinic situation. In addition the Affect Adjective Checklist was administered as a measure of felt anxiety, hostility and depression. Each of the six sessions thereafter lasted 20 minutes and was to be reinforced with homework practice. Prior to treatment, four of the nine patients were assessed as adjusting well to their clinic experience, while the remaining five patients exhibited problematic behaviors, primarily anticipating vomiting. Post treatment observations indicated that the stress inoculation techniques were beneficial in altering anxiety-related behaviors.

This was a small number of clients studied over a short period of time as a pilot project. Before the study had been completed, two of the clients had died and four were in rapidly progressing metastatic disease. This pilot project was used as a learning device and major alterations were planned prior to the establishment of a standard program. Numerous others have since taken on the task of studying stress reduction methods for the cancer patient.

NON-CONVENTIONAL METHODS

Biofeedback

Articles have been written on biofeedback that could be applied to the cancer patient, however, the use of biofeedback for those persons with terminal cancer appears

to be limited to the control of symptoms of pain, nausea and vomiting. It is not advocated that this approach be introduced late in treatment when symptoms have already been well established. Rather, it is recommended that measures be taken prior to therapeutic treatments that tend to result in either pain or nausea/vomiting; somewhat like preparing for natural childbirth. However, no studies have yet been found illustrating this pre-symptom approach.

McCaffery (1979) states:

Biofeedback, loosely translated, means feedback about the body, or providing information about the current status of some body function. The information is fed back to the person whose body it is. The goal is to gain control over a body function and then be able to maintain the control in actual life situations" (p. 139).

Monitored information feedback can inform the client of the amount of muscle tension, body temperature, blood pressure, and brain waves. The client may hear an increasing or decreasing pitch of a tone that represents changes in muscle tension. Biofeedback of muscle activity or relaxation is done by EMG (electromyogram). Some form of relaxation exercise almost always precedes a biofeedback treatment.

Autogenic training which stresses concentration on specific types of physiological and mental functioning may be one pre-treatment approach. This involves six psychophysiologic exercises practiced lying down in a quiet environment with the eyes closed. A passive concentration

is encouraged--a "let it happen" attitude. Exercise 1 focuses on feeling of heaviness of the limbs; exercise 2, feeling of warmth in the limbs; exercise 3, cardiac regulation; exercise 4, concentration on breathing; exercise 5, warmth of the upper abdomen; and exercise 6, coolness of the forehead.

B. Segal, D. Bresler, and I. Progoff incorporate autogenic training in their seminars for patients and health care workers. The use of biofeedback by a client encourages in-depth self awareness and a high degree of self-responsibility in caring for one's own health. Brallier (1988) offers a word of caution to those persons wishing to do biofeedback with clients. In the process of the client practicing with the instruments, very complex and deep psychological issues come up spontaneously and may be accompanied by emotional reactions. These reactions are best dealt with by on-the-spot psychotherapy rather than only supportive measures.

A therapist able to employ multiple modalities is more likely to provide a holistic therapy experience, allowing healing to progress in a way that includes the deepest levels of the self" (p. 32).

Bromley in Zahourek (1985) points to the controversy in the relationship between hypnosis and biofeedback. Both methods compare in their involvement of cognitive regulation of autonomic functions and both employ distraction. However, they differ in that hypnotic techniques stress modes of pain denial, whereas biofeedback emphasizes the

development of sensitivity to bodily processes. Biofeedback is a newer field of research in cancer care. To make contact with persons working in the field or to obtain information readers should write to the Biofeedback Research Society, University of Colorado Medical Center, Denver, Colorado 80262.

Meditation

Endomeditation

Endomeditation is a technique developed in 1980 by L.S. Milner, M.D., a Chicago area hematologist, that combines the psychologic and physiologic benefits of meditation with those of self hypnosis and acupressure. He emphasizes that it is recommended to aid the relief of side effects of standard forms of cancer therapy and not intended as a cure.

With EM, auditory stimuli from the heart sounds are used to disrupt the pathways for nausea just like needles do in acupuncture. By forming an intense circle of concentration between the sounds and the mind, noxious effects of the drug can be blocked from conscious awareness without affecting the chemical reactions themselves. It is only the latter which need to occur for tumorcidal effects and by preventing much of the secondary nausea and vomiting patients experience enabling them to undergo more extensive treatment programs. Because a patient can prevent much of the physical illness, they will be able to conserve their strength and maintain their weight (p. 63).

The technique is performed prior to, during and for a short time following drug injections. The patient is instructed to lie flat breathing deeply through the nose. Reinforcement instructions are given for a full minute before a period of complete silence. A specially fitted

amplified stethoscope is placed in the patient's ears and he is instructed to concentrate over and over on the sounds of the heart. He is instructed to maintain this concentration on the heart no matter what other feelings seem to arise and to form a "circle of concentration" from the sounds of the heart to the mind creating a rhythmical hypnotic pattern. With the ear pieces in place, other auditory stimuli are blocked out providing a better media for meditation to occur. Breathing should be slow and regular through the nose rather than the mouth since this will keep the breath sound intensity to a minimum. The repetitive sound of the heart beat serves as a mantra. Milner suggests that if a state of anxiety is accompanied by a rapid heart beat, the heart rate can be slowed prior to EM using other relaxation methods. He states,

You can sometimes differentiate a stressful situation that is primarily emotional in origin from one that involves the entire sympathetic system by a simple measurement of the heart rate. If the heart rate remains below 80 beats per minute in most people with normal cardiac function, stress is being felt primarily as an emotional response and not by the entire body. If the pulse rate is greater than 80 beats per minute the differentiation is much more difficult (p. 27).

Since all forms of meditation require intense concentration, this form of Rx may not be adaptable to every client. However, Milner relates that at the time of his initial introduction of this concept,

every patient so tested has stated that not only do they have none of the symptoms which had been so disruptive before but that they feel refreshed and rested as well (p. 64).

He states that the technique is simple and does not take up more office time than that required for the injection itself. Since the patient purchases both the brief text and special stethoscope, the technique can be utilized by a self motivated client in the home where the often delayed reactions occur. Milner suggests that the minimal cost and effort of this technique make it cost effective and more desirable than trips to an expensive emergency room for symptom control.

Dr. Milner is one of a growing number of physicians who believe that there is now evidence that the mind can control bodily functions. At the time of the printing of his book, no scientific studies had been employed to test the true effectiveness of his method. In addition, it does not appear that an emotional assessment is made prior to the intervention.

Process Meditation

In a similar but more intense and self committed method of meditation is that created by Ira Progoff (1975). This method of meditation can be conducted alone or in a group. The initial teaching of this method is usually done in a group setting. An extensive meditation period is followed by a "hot pen" method of recording one's thoughts of concerns, problems or conflicts in a journal. This in turn progresses to a dialogue between the self and various concepts i.e. the self and illness, obesity, pain, God,

diseased body parts or death. The journal is an ongoing self help method for discovering conflicts. For the cancer patient, the dialogue between the self and an afflicted body part may help to uncover thoughts, feelings and concerns never before realized. Some Gestalt therapists utilize this method to uncover and work through conflicts as a part of their general psychotherapy.

Realization with acceptance of and/or resolving the conflict is said to result in a sense of quieting, relief and peace. Progoff recommends his method especially when experiencing a "cross-roads in one's life; when the decision of which path to take" is unclear. For the cancer patient, the cross-road may be whether to remain employed or a time to give up employment, choosing between various treatments or to examine the meaning of life and its ongoing forms of change including death itself. This cognitive-behavioral approach can be very powerful. Part of the power is said to be in reading the dialogue aloud in the company of a therapist who can offer comments and suggestions for further thought exploration. In the more advanced stages of cancer, when fatigue is all consuming and when much strength and coordination are affected, the use of a tape recorder can be used with the tapes played back for the therapist and self listening. This can both help to conserve the energy used in speaking as well as a memento to be left for one's survivors.

Research data concerning Progoff's method specific to cancer patients appears to be lacking in the volumes of materials reviewed, however, its applicability is beyond question. It has been used to explore life planning and its uncertainty, issues of body image, areas of emotional as well as physical pain and can be done alone or with guidance of a therapist.

Relaxation/Imagery

Irvin Olye (The Healing Mind, 1975) believes that armed with a variety of guided imagery techniques multiple medical problems can be treated, including cancer. To treat is not necessarily to cure, but rather, to help in some way. He believes that we are normally in contact with only 10 percent of our brain and that guided imagery is a way to find out what the other 90 percent thinks about.

An imagery technique, known as cognitive rehearsal is designed to visualize the various steps involved in a task. The concentration on detail aids in the actual completion of the task, deters daydreaming or ruminating and helps to note potential obstacles. This is a form of problem-solving in fantasy prior to attempting a behavior. Sometimes it is possible to assess what has blocked a particular response; it may become clear why a patient has stopped engaging in an activity which has been pleasurable.

Among those who are well known in the literature for using imagery with cancer patients include the Simontons

(1978), Achterberg/Lawlis (1984), and Bresler (1979).

perhaps the Simontons are the most read, most mimicked and most criticized of those engaged in the use of imagery.

This husband/wife team from Fort Worth once co-conducted workshops, seminars and extended courses for medical, lay personnel and patients in the process of various uses of imagery. Their work continues, though now practiced individually, in California and Arkansas respectively.

The Simontons delineate a holistic concept of etiology and intervention for cancer patients. Wellisch (1985) in his review of visualization therapy, identifies a major tenet of the Simontons to be the possibility of a cancer prone personality. Since the major consensus among their colleges reduces this to an interesting but unproven speculation, much of their work has drawn criticism. However, it appears more clearly that the belief system of the person and his locus of control are their greater focus, especially, a cancer patient's beliefs about their disease. "His beliefs about his disease, his treatment, and himself are very big factors, having a significant role in the course his body takes during and after treatment" (p. 31). They require their clients to assume an internal locus of control, however, upholding a further reaching holistic premise that expands Abramson's (1978) concept of "internal/personal." In searching for a cause to cancer, they include other contributing factors as carcinogenic

substances, genetic predisposition, radiation, and diet which may over stress the immune system making one more prone to disease. They therefore support certain changes in life style.

The core of their psychotherapeutic process consists of the acceptance by patients of the belief that they must participate in combating the disease process, and must similarly accept responsibility for the disease" (Wellisch, p. 236).

In response to much criticism that they strongly believe and promote that patients cause their own cancer, they caution that responsibility is not blame and state:

For some reason we (as a society) have a conception of responsibility being the same as blame. This is one reason for our inability as a society to deal with the emotional aspects of our diseases. We feel that if we accept responsibility we are to blame, should feel guilty, or have done something wrong (1975, p. 39).

They suggest that when the question of "why me" surfaces, that many facets in the person's life and life style be viewed and that they be treated as individuals and not as a generalized group of statistics. They uphold the work done earlier by LeShan (1977) where those who saw themselves as "victims" of the stresses that their individual lives imposed, tended to feel hopeless/helpless and in despair for some months prior to the onset of disease. "This process does not cause cancer, rather it permits cancer to develop" (p. 63). The Simonton's grant their clients a permission to change that process. They state:

The crucial point to remember is that all of us create the meaning of events in our lives. The individual who assumes the victim stance participates by assigning

meanings to life events that prove there is no hope. Each of us chooses--although not always at a conscious level--how we are going to react. The intensity of the stress is determined by the meaning we assign to it and the rules we have established for how we will cope with stress.

In outlining this process it is not our intention to make anyone feel guilty or frightened--that would only make matters worse. Instead, we hope that if you can see yourself in this psychological process, you will recognize it as a call to action and make changes in your life. Since emotional states contribute to illness, they can also contribute to health. By acknowledging your own participation in the onset of the disease, you acknowledge your power to participate in regaining your health and you have also taken the first step toward getting well again (p. 63).

What they offer cancer patients who seek their assistance is an intensive six week program of prescribed activities. These include identifying major stresses that occurred six to 18 months prior to diagnosis. A type of self examination follows and is intended not to invoke guilt but to identify behaviors to be changed if one is to live full and healthy lives. By becoming aware of certain stresses, the search is then made for finding more effective ways of coping with them so that they can free energy to fight their disease. Clients are encouraged to keep reading books that interrelate body/mind/emotions. A three times daily program of relaxation and mental imagery is suggested. Audio tapes are provided to assist with this and to reinforce the process during periods of increased stress i.e. chemo administration, radiation therapy or other treatment procedures. Because the content of imagery varies with the person's psychological state at a particular time,

a guide or facilitator of learning i.e. a counselor/psychologist can assist the person to substitute negative images with positive ones. Mental imagery is symbolic and highly personal language and interpretation is similar to interpreting dreams. While a symbol may represent strength, power and healing for one individual, the same may represent anger and hostility for another person.

Physical exercise is included in the program and is prescribed one hour, three times weekly. It is one devised effective for heart patients. If bedridden, the suggestion is made to visualize engaging in exercises. Even though connected to an intravenous feeding, some exercises are able to be done in bed i.e. moving of head, arms and legs. In addition mental imagery of a favorite activity--playing tennis, swimming, walking through the woods can also be employed. The idea of the body in motion connotes something that is actively living and leads to an emotional climate conducive to healing. Patients are encouraged to assert themselves in setting a time frame for engaging in this mental/physical exercise, an assertiveness that translates as--"I am important," and "I have a right to feel better."

At the time of the printing of their book, they related that the connection between diet and cancer was still being researched. However, based on more recent scientific discoveries, changes in diet or caloric intake may now be yet another area for behavior change incorporated into the

visualization process.

Clients are also told to set goals--"three goals each for three months, six months and one year away" (p. 94). Such goal setting helps to create a future. Finally, finding one's Inner Guide--the unconscious resource for healing and strength is taught through the imagery process. This inner guide takes the form of a respected authority figure with whom the patient can carry on an internal conversation. The idea of an inner guide comes from Jungian Psychoanalysis and is also utilized by Progoff (1975) and Bresler (1979). During the process of their therapeutic encounter with clients, the Simontons help patients deal with anger, hostility, resentment and the fears of cancer recurrence and death. The inclusion of the family or significant other as a support system contributes to their holistic approach to patient care. Their program has served as a training ground for many other professionals who have incorporated it into their therapeutic approaches. They have also contributed to the resurgence of the Holistic Health Care movement which today promotes and utilizes the concept of self caring.

In their discussion on imagery, Achterberg/Lawlis (1981) refers to the therapist using imagery techniques as being an "advocate-shaman-therapist". "Advocacy expresses the ideal that individuals should be positively assisted in exercising their freedom of self-determination and self-

control" (p. 209). Such a position of self responsibility may entail bucking the system. This may take an incredible amount of energy for the patient/client and may eventually lead to the restriction of the advocates activities within a medical facility. However, the three goals of self-determination, self-control and self-responsibility are part of a humanistic behavioral medicine.

The therapeutic approach utilizing the technique of imagery should take into consideration the patient's value system, attempt to clarify that cognitive system for both the patient and the therapist and work creatively with those elements that appear to serve the patient's best interests. It is as important to foster a patient's comfort as it is to use aspects of his belief system to help resolve conflicts. The use of imagery integrates metaphor with the concrete. "Imagery itself refers to the products of the imagination, or the images, that appear to be the precursors of verbal behavior both in ontogeny and phylogeny" (Sobel, 1981, p. 211). Images are more basic than language and very vivid images are correlated with physiological change and bridge the mental and physical function. Imagery as defined by Achterberg/Lawlis is "a cognitive representation of any sensory function without the external stimulus that normally triggers the sensory pathways" (p. 211). This definition includes not only visual, but also auditory, olfactory, and the kinesthetic.

Their 1977 and 1979 work examining imagery was an attempt to predict response to treatment based on cancer patients' psychological profiles as well as their blood analysis.

Consistently, the patients' images of their disease, their treatment, and their immunological system - scored and objectively measured using a projective instrument called the IMAGE-Ca (Achterberg/Lawlis, 1978) - were the most powerful predictors of follow-up physical status. ... It appeared that the images patients hold; often unconsciously, indicate future directions in disease (p. 212).

Their use of imagery with patients with life-threatening disease are categorized into four basic functions:

(1) to clarify the disease and treatment process itself by patient education or image programming; (2) to develop coping mechanisms to counter fear and pain; (3) to enable material stored at preconscious or unconscious levels to emerge as clarifications of value systems and to assist in the resolution of past issues or future planning; and (4) to react and interact sensitively with a patient's own dying images (p. 212).

Education sessions are preceded by relaxation instructions and exercises in order that information may be more easily retained. This is followed by information on the disease, on treatment and on healing mechanisms, using media products. It stays consonant with information on the disease, yet focuses less on images of deterioration than on stabilization or healing. These behavioral and cognitive components are strategically integrated with client-centered psychotherapy intervention sessions.

Imagery as a coping tool is introduced for

desensitization of noxious stimuli while the individual is in a relaxed state. The fear of the disease of cancer developed prior to diagnosis may double when faced with the reality of the illness and ensuing treatments. This fear of the disease may be more of a detriment to a healthy lifestyle than are the symptoms themselves. Repetition of audio-visual material may be needed regarding the disease during the relaxation periods. The individual is given substitute mental pictures capturing the process of healing. Instead of visualizing tumors growing without control, patients can develop substitute images of chemotherapy or white blood cells destroying tumors. An example is given concerning imagery to control pain by a man with a rapidly growing head/neck cancer. He used the relaxation exercises. He would then imagine a bulldog as a "pain eater." When pain occurred he'd set the bulldog loose to take large bites out of the pain, and for him it worked therapeutically.

Healing images offered when a patient is in a relaxed state are meant as substitutes for any negative mental pictures. It is suggested that patients focus on developing images of white blood cells or chemotherapy destroying tumor mass vs. the negative of seeing the tumor mass growing out of control.

Imagery is also used as a means of obtaining clarification and resolution. It allows for the free flow of thoughts from the unconscious, giving them interpretation

and meshing that information into present awareness as a cognitive/behavioral determinant. Imagery trips have assisted patients with planning and also to review complex questions for decision making. While decisions cannot be forced, after a period of relaxation and free flow of thought from the unconscious, decisions will evolve to the more conscious level and frequently result in a sense of relief.

Personal experience has shown that those persons in the terminal phase of their terminal illness tend to use more symbolism in general conversation; to the untrained ear, this is often dismissed as mental confusion. Much can be learned from these patient's inner life when one asks a few basic questions to illicit interpretation. The images or visions must be handled with care by those caretakers not afraid of death. Terminal patients frequently will address certain presences - sometimes a deceased parent. Reference is made to "death" or "love" and they often refer to the transgressing readiness to go "home".

David Bresler, director of the Pain Control Unit of the UCLA Hospitals and Clinics is also a professor of neurosurgery, anesthesiology and psychology. He has done an extensive amount of work in the area of pain control, including the eroding pain experienced by cancer patients. He bases much of his thinking on the previous work done by Green, LeShan and Kissen in the 60's and supports the

concept of stress related illness.

In his book, Free Yourself From Pain (1979), drugs and surgery are deemphasized. He teaches his patients to draw upon their inner resources to help overcome discomfort. He incorporates various exercise charts that include, a Daily Comfort Log, Life Chart, Your Goals, Corresponding With Your Discomfort, Discovering Pain's Message. And to gain inner perspective, he uses the imagery techniques of Reexploring a House and Beyond the Door. Patients are to make and record on each chart, their own interpretation. He also encourages the use of art, no matter how elementary, to put concreteness to images.

No where in the literature has there been found a clearer method for learning about the use of an "Inner Advisor" than in the material by Bresler. His 479 page text, written for the medical profession is also used as a patient/client guide and includes in addition to the many charts, vivid descriptions and samples of dialogues.

Unlike the Simontons who suggest that the inner advisor be an authority figure, Bresler promotes the use of a non-threatening figure as an animation - a friendly animal that eventually assumes the voice of the unconscious. It is advised that this figure be treated with care and nurtured with attention and friendship lest it run away out of fear. This technique is a fascinating form of "guided imagery that allows patients to communicate actively with the non-

dominant part of the brain and in turn reach a more complete understanding of their pain experience" (p. 397). Not only is the use of an inner advisor used by Bresler, but also the technique of personifying the concept of pain and dialoguing with it to help in problem-solving (see Appendix C). This is very similar to Ira Progoff's (1975) method of inner dialoguing to find solutions to problems.

Bresler seems to incorporate all that Progoff, the Simontons, LeShan and Achterberg and Lawlis have offered and added from his own medical background aspects of neurophysiology and anesthesia. He uses a form of hypnosis or "mind-controlled analgesia" (MCA) and glove anesthesia as an extension of the conditioned relaxation exercises which involve purely psychological processes. Through this exercise, pain can be mobilized from one body part to another i.e., from the lung to a hand, and then allowed to flow out from the finger tips or sweat glands. This displacement of the pain allows the affected body part to find rest and relaxation in order to handle the pain better on its return. This can be very helpful for cancer patients. This short reprieve from their pain may be viewed as a mini vacation. Since audio tapes are available for each of the topics covered in his book, these exercises can be done alone without needing to rely on a physician. Bresler encourages independence and self care and works in the realm of Holistic medicine. The imagery, dialoguing and

use of an inner advisor allows one to free any anger or fear that might be blocking one's problem solving abilities.

Reference notes for each chapter of his book, provide information of other sources including names and addresses for obtaining further data of each topic discussed.

In conversation with Dr. Bresler, it was pointed out that pain is an indication of something being wrong in the body and that to mark that pain through psychological means could be quite harmful. In addition, expectations for relief are perhaps unrealistic. He agreed that masking the pain before its message is heard may not be in the best long-term interest of the patient and emphasized the need for thorough evaluation before these exercises are employed.

Jay, Elliott and Varni (1986) identify subtypes of pain - disease related vs. treatment related, with disease related pain being more chronic and treatment related being generally but not always the more acute. Bresler's methods could be applied to the chronic intractable pain caused by progressive disease. Once the exercises are well learned, they could be exercised during painful procedures that create acute pain. Bresler points out that pain is a very complex experience and that it is unrealistic to expect that one acupuncture treatment or brief use of an exercise will remove all the pain. Rather, much depends on how the client perceives both his pain and his treatment.

Bresler also answers the question of who would not be

good candidates for this approaches. Guided imagery is not recommended for people who are emotionally hysterical, mentally unstable, schizophrenic or prepsychotic.

Interestingly, we have found at UCLA that alternative pain-alleviation techniques are often less effective for patients who chronically use opiate-based analgesics. If you're taking Demerol or Darvon, procedures like acupuncture or guided imagery may not provide much relief. Why? Well, particularly with acupuncture, I think the problem may be that the endorphin receptors become desensitized due to the long-term use of large doses of narcotics. So even though acupuncture may cause the nervous system to release its own natural pain reliever, it can soon become ineffective when the critical receptor sites no longer respond to endorphin release.

For patients who have been taking large amounts of narcotic analgesics, I almost always recommend that they gradually reduce their drug intake in order to reactivate their endorphin receptors once again. After complete withdrawal is achieved, I find that patients typically respond much better to acupuncture, guided imagery, biofeedback, and other minimally invasive procedures (p. 222).

Visual imagery is used to reach feelings which patients are often unable to verbalize and of which they often claim to be unaware.

Perhaps the most useful aspect of the imagery technique involves giving permission to experience all the images that will allow the patients themselves to resolve any issues they need to, at the point in their 'therapy' when they are ready. Within the image, the patient interacts with some 'significant other' and is told what they need to hear to resolve their inner conflict. A related approach involves spiritual 'awakening' or contact from which the patient gets the feeling of strength to survive and carry on (Rosenberg, 1982, p. 127).

In their review of the literature on pain, Jay, Elliott and Varni (1986) report that approximately 700,000 persons are diagnosed with cancer annually in the United States.

Their surveys indicate that approximately 40% of those with intermediate stages of cancer experience moderate to severe disease related pain, while 60% to 80% of those in the advanced stages of the disease report the presence of pain. When this disease related pain from tumor invasion or infiltration is assaulted by procedure related pain such as bone marrow aspirations, spinal taps, gastric x-ray preparations, rectal exams, etc. the person may feel invaded, violated and terribly overwhelmed with discomfort. Jay, Elliott, and Varni also subdivide pain into acute (time-limited), and chronic (long standing). It is this chronic intractable pain caused by progressive disease that leads to what they describe as "abnormal illness behavior" that includes sleep and appetite disturbances, decreased activity - both physical and social - and emotional problems such as depression and anxiety. The authors suggest a multimodal assessment plan be implemented that encompass behavioral, cognitive-affective, and physiological response systems. They advocate the use of behavioral observation scales, self-reported/self-rated pain and any of the wide variety of pain questionnaires and checklists available. After all these evaluative measures are taken, it is then time to treat the patient. The choice and method of treatment is left up to the individual clinician's preference and skill. For years, cancer pain has been inadequately managed from a medical standpoint. From the

study done by Bonica, 1980, little information about pain problems can be found in the oncology literature. Patients are frequently underdosed with medication out of ignorance that vital signs will change and result in death. Hence, the patient frequently must suffer in pain in order to maintain a lively heart and respiratory rate. Some patients in pain tend to "guard" and hold their breath or breath more shallow respirations. Observing these changes in respiration, frequently leads to an automatic withholding of medication for pain relief. Since these practices are quite prevalent, it is even more necessary for those involved in psychological practice to begin early in the patient's stage of disease progression to teach the patient, self imposed methods to aid pain relief and other uncomfortable symptoms.

Relaxation techniques preempt any attempts at behavior modification for control of pain or the side effects of chemotherapy, regardless of whether mental imagery, hypnosis or a combination of the two are used. Numerous authors have written about the beneficial effects of relaxation and the use of the technique in the case of the cancer patient. Few actual studies concerning relaxation have been conducted and most tend to be limited to the control of nausea and vomiting by the nursing literature (Cobb, 1984; Donovan, 1980; Kaempfer, 1982; Sims, 1987; Tamez, Moore & Brown, 1978).

One non-nursing research study conducted by Lyles et

a1. (1982) involved 50 cancer patients receiving chemotherapy. The purpose of the study was to examine the effectiveness of relaxation training and guided imagery in reducing the aversiveness of cancer chemotherapy. Patients were assigned to one of three treatment conditions: 1) relaxation training plus guided imagery; 2) therapist presence with emotional support and encouragement; and 3) no treatment control. The results supported the use of relaxation and mental imagery in reducing tension and lessening nausea and vomiting, as well as reduction of physiological arousal measured by pulse rate and systolic blood pressure. The same clients also reported less depression and nausea in the post treatment phase. There was little significant difference between the group receiving therapist support and encouragement and the no treatment control group.

McCaffery (1985), along with Breden (1976), utilize relaxation with guided imagery for pain control. The use of relaxation training as a technique requires a quiet environment, a comfortable position, trust in the therapist and a passive attitude. A frequently used induction of relaxation, the progressive muscle relaxation method is contested by some authors but is none-the-less the most frequently used induction. It is done by progressively tensing and relaxing different muscle groups. The individual is taught to discriminate between feelings

experienced when a muscle is tense compared to when it is relaxed. Since Jacobson first introduced this method in the 1920's, numerous other clinicians have modified and altered the technique giving it more variety of style. Kaempfer (1982) reflects this particular practice of induction stating that the problems that arise from tensing muscles may increase pain. In addition, she, as well as Thompson (1978), comment that this activity may generate increased somatic preoccupation and that this added body awareness could provide another source of stress to the patient. McCaffery (1979) agrees with Kaempfer and Thompson that some patients are not candidates for the relaxation technique especially when a meditative approach allows the mind to passively take in an awareness of all stimuli, both internal and external. The required amount of concentration needed to practice this may not be possible for the person in great pain and a sense of failure may evolve when attempts are thwarted. The idea that relaxation training could be harmful may at first seem contradictory; however, when intense disease or treatment related fatigue is present vs. tension related fatigue, the exertion required to practice this may exceed the real amount of available hidden energy, especially for the patient in advanced stages of illness. In one study (Jacob, 1975-76) it was concluded that those cancer patients who were selected to practice progressive relaxation felt a certain added energy to cope, however,

their pain was not necessarily relieved. It is pointed out by McCaffery and others that relaxation techniques need to be individualized to suite patient's needs, preferences and previous experience with relaxation, something not possible in a formalized research study. McCaffery lists some of the positive effects of relaxation techniques when used for pain:

When a patient with pain uses a relaxation technique it may

1. reduce the effects of stress. Stress may be of two general types: a) stressful events that cause or aggravate the pain, or b) pain itself.
2. decrease acute anxiety.
3. act as a distraction from pain.
4. alleviate skeletal muscle tension or contraction that is creating potentially painful stimuli.
5. produce a state of increased susceptibility to suggestions of comfort.
6. combat fatigue and/or facilitate going to sleep.
7. enhance the effectiveness of other pain relief measures (p. 143).

Scripts are provided by most of the authors of relaxation techniques either in their published texts or available by writing to them.

Imagery is considered to be

the primary focus of therapeutic process in some 20 psychotherapeutic approaches including psychosynthesis, psychodrama, Gestalt therapy, transactional analysis, Gendlin's 'focusing' process, Jung's active imagination, Lazarus's emotive imagery, hypnosis, systematic desensitization and symbiotic modeling (Gagan, 1984).

The guided affective imagery technique developed by Leuner in Germany and published in 1969, utilizes three basic images following induction with relaxation exercises.

These include the meadow image, the mountain image and the brook or stream image. These were first intended for use in the exploration of potential conflict and possible personality growth, and have been adapted by many contemporary practitioners.

Shorr (1976) took the process of guided affective imagery a step further by developing "task imagery" in which a client is requested to visualize himself working through a particular task or conflict in a concrete problem solving nonsymbolic imagery. Imaging a task being accomplished often reveals attitudes that the client has toward himself and the world.

Witmer and Young (1985) identify two factors responsible for a renewed interest in imagery as a tool for counseling.

First, an emerging eclecticism heralds a movement away from strict adherence to schools of counseling and psychotherapy and toward an integrated cognitive-behavioral approach. Second, new developments and discoveries in brain research and health psychology have legitimized nontraditional therapeutic approaches (p. 187).

The authors refer to imagery as the silent partner in counseling. Their list of references include some of the more current sources for the use of this technique in the field of psychology. The other disciplines of Medicine, Nursing, and Social Work have borrowed from Psychology and incorporated the use of imagery into the other half of health care - the medical arena (Bry, 1978). Currently,

imagery has been used in cardiac disease, obesity, insomnia, chronic pain of many types, as well as with cancer clients to help improve the quality of life.

Those who believe that a positive mental attitude can be cultivated with the use of visualization, also believe that changes result from imaging the reality (Gagan, 1984). Despite the current outcome research and increasing use of visualization and positive mental attitude, two well known people in the field of cancer care, Dr. Barrie Cassileth of Philadelphia and F.I. Fawzy of UCLA contend that one's attitude has no influence over the disease of cancer. They stand firm in their belief that cancer is neither caused or helped by attitude of one's belief system.

Research in the area of imagery has been noticeably limited. However, extensive work has been done by J. Achterberg and F. Lawlis who developed the Image-CA instrument, in an attempt to predict response to cancer treatments based on psychological profiles and blood analysis. They incorporate patient's images of their disease, treatment rendered, and their immune system. Their research thus far indicates that the images held unconsciously indicate future direction of the disease process. Early in their text "Imagery and Disease" (1974), they state:

The ability to form visual images has been examined by several investigators and found to correlate with psychological traits and abilities. Among those traits where a positive correlation exists are hypnotic

susceptibility (Palmer & Field, 1968; Wagman & Stewart, 1974), ease of verbal learning (Paivio, 1969), personality characteristics of introversion/extraversion (Huckabee, 1974), conclusion in consciousness (Richardson, 1969; Sheehan, 1973), and creative self-perceptions (Khatina, 1975).

Despite widespread interest, the measurement of the imagery experience, per se, remains a complex impediment to the understanding of the process since it consists of intrinsically private events which have remained externally unverifiable. Since complications are not new to psychology, however, since the "core" areas of the discipline such as learning, motivation, and perception have also been fraught with all the problems of the verification of hypothetical constructs (p. 6).

Their research identifies significant correlations between imagery ratings and pre to post changes in white blood cells function during visualization.

Predictive Studies

Whether the images of cancer, as measured by the Image-CA, are correlative factors reflecting a sort of "body wisdom," or whether they could also be causative in terms of inducing physical change, has remained at the core of the controversy surrounding the use of imagery as a therapeutic tool. The fact that the Image-CA was predictive of subsequent disease change as well as the literature reviewed earlier which demonstrated the potency of imagery in altering physiological function would suggest an element of causality. In order for imagery to have any effect on cancer remission, though, it would logically have to impact upon and, in some unknown way, direct the functioning of the immune system. A series of investigations designed to test this notion was conducted by John Schneider, C. Wayne Smith, and Sarah Witcher (1983) and Christine Minning at Michigan State University (1981). The studies are of great interest here because of the demonstration of control over specific immune functions, and also because of the modification of the Image-CA that was used to correlate blood variables with imagery (p. 141).

The authors address the use of imagery as a therapeutic technique, as patient education, as a coping tool, as means

of clarification and resolution and as reality for the dying. "Dying imagery seems to be like a pilot's communication as the plane approaches a landing. It is a dialogue with an unknown entity..." (in Sobel, 1981, p. 220). These clients have been known to have a deep integration of religion into their lifestyle. An example is given of a woman who reported the appearance of Jesus at the foot of her bed and described new tumors in the woman's brain. Her physician reluctantly ordered a brain scan and the beginning of brain metastasis were discovered. These images are quite different from psychotic hallucinations that are typically nonintegrated and often only auditory. Osiris and Haraldson (1977) found that in most cases these visions are not related to drugs or to products of disease. Following such images are changes in mood - typically elation and a sense of peacefulness.

Some examples appear in the literature of clients who have been encouraged in the use of imagery only to develop negative and destructive images instead of those that are health promoting. In these cases, there is a lack of illustration of how to reverse the image patterns. This is an admitted challenge to the use of imagery in all phases of health care and especially when the diagnosis is terminal. The reversal would seem to be dependent on some expression of hope or faith by those involved in aspects of care, as well as a desire by the client to actively pursue life.

While Freud developed a technique called "free association", it was Jung who can be accredited with the development of several innovative imagery techniques designed to explore aspects of the unconscious. Application of guided imagery techniques are being used by a convinced and growing number of therapists.

Relaxation/Hypnosis

Cerio (1983) describes the fantasy relaxation technique developed by H. Gunninson in 1976 as a simple method of gaining control over panic and anxiety. FRT consists of three components: 1) systematic relaxation of the different muscle groups, 2) rapid relaxation using the countdown of numbers, and 3) imagery. While the work addresses problems of panic associated with the taking of exams by students, it can quite readily be applied to the cancer patient and the problems of panic and anxiety associated with physical exams and repeated painful procedures.

It is suggested that the therapeutic effects of relaxation may have both physiological and psychological benefits. The physiological responses to relaxation are the reduction of hypertension, alleviation of muscle tension and insomnia, decreased pain and increased comfort. The psychological benefits are that such an exercise can be self-induced leading to a sense of control, decreased anxiety and peace of mind.

Table 6 gives a summary of the various relaxation

Table 6

Summary of Relaxation Techniques

Technique	Advantages	Disadvantages
1. Relaxation Breathing breaths slow and deep until relaxed	. Can be used for acute pain along with other relaxation	. Leads to hyperventilation if done incorrectly
2. Progressive Muscle Relaxation Alternately tenses and relaxes major muscle groups	. Can distinguish between tense and relaxed muscle . Relieves pain . Makes activity easier	. May cause added pain in disorders as trigeminal neuralgia
3. Autogenic Training The client replaces painful sensations with pleasant relaxing ones through self suggestion	. May help induce sleep	. Involves much training with a coach
4. Guided Visual Imagery Client imagines a peaceful, pleasant scene to divert from pain. Used with progressive muscle relaxation. Simonton method: visualize destruction of cancer cells	. More lasting effects than with some of the other techniques	. Requires ability to dream, vivid imagination, deep concentration and quiet surroundings

Table 6 (continued)

Technique	Advantages	Disadvantages
<p>5. Self-hypnosis Client concentrates on positive image. An altered state of consciousness</p>	<ul style="list-style-type: none"> . Post hypnotic suggestion may aid in pain relief . May help client feel more in control of daily situations 	<ul style="list-style-type: none"> . Can increase anxiety in highly anxious persons . May trigger traumatic or painful memory . Not recommended for psychotic or schizoid prone persons . Requires training by qualified therapist
<p>6. Biofeedback Gives client information biological functions usually through electromyograph</p>	<ul style="list-style-type: none"> . By recognizing the biological functions (e.g. relaxation) can be trained to control the function 	<ul style="list-style-type: none"> . Requires client travels to site of machine . Performed by another person
<p>7. Slow Stroke Massage Slow, rhythmical strokes of light pressure using both hands</p>	<ul style="list-style-type: none"> . Helps relieve tension . Stroking pain site reduces pain transmission . Increases circulation and and skin integrity 	<ul style="list-style-type: none"> . Most always performed by another person

techniques with advantages and disadvantages.

Hypnosis incorporates relaxation and imagery. Newton (1983) states that

hypnotic imagery is seldom separated from relaxation. It is basic to all that we or the patient can do in treatment, because relaxation has important beneficial effects such as lowering anxiety; altering moods; reducing perceived pain and the distress of symptoms and it seems that the deep quiet achieved makes it possible for healing to take place (p. 105).

Cobb (1984) has developed a Relaxation Therapy Patient Teaching Plan that provides Objective, Content, Teaching Actions and Outcome Criteria. Her overall objective is to help cancer patients cope with pain and decrease the anxiety and side effects associated with various treatments. Current relaxation literature is also reviewed. She lists the available relaxation techniques as: 1) Transcendental meditation, 2) Hypnosis, 3) Progressive muscle relaxation, 4) Guided imagery, and 5) Cognitive modification. She emphasizes that the choice of method depends upon both availability and the clinicians as well as patient's personal preference. An assessment must be made prior to teaching any relaxation technique that includes an evaluation of the need to learn, readiness and motivation to learn.

Viewing relaxation as a skill and acknowledging that skills are perfected through practice, the patient/client must possess the necessary tenacity to keep focused and practice learned material frequently. This in itself may be

a very difficult task since a frequent problem that cancer patients face with progression of disease is a profound weakness accompanied by fatigue. Weakness and fatigue are known to effect concentration powers for mental agility. Most relaxation training is currently being done through individual instruction which allows for privacy and adaptation of the teaching plan to suite the individual learner. The clinician needs to evaluate the effectiveness of this one to one coaching with any necessary follow-up training sessions. Tape recordings can supplement individual instruction and follow-up.

Those persons with cancer who may benefit most from relaxation training are those 25% who generally experience anxiety in relation to procedures, side effects from treatments, pain associated with high anxiety, muscle spasms and those receiving chemotherapy and radiation therapy. One factor missing in Cobb's article is the element of trust - both trust in the clinician as a person and his skills and also the individuals own self-trust. This concept of trust needs to be considered during the assessment of the client, perhaps under the category for readiness to learn. This topic of trust seems to be especially important when hypnosis is the method of choice as adjuvant therapy with the cancer client.

Hypnosis was officially accepted in the United States medical community in 1958, but had been researched and

practiced many years earlier in Europe (Zahourek, 1987). since the 1950's a large number of therapists have engaged in hypnosis to aid cancer patients. Some of the major contributors in the area include: Aranoz (1983), Barber (1982), Bresler (1979), Hall (1982), Hilgard (1973), Kaye (1987), LeShan (1977), Liss (1982), Margolis (1982), Newton (1982-83), Redd et al. (1982), Rosenberg (1982), Sacerdote (1965-1978), Siegel (1989), Spiegel (1978-1985); Zahourek (1987).

Zahourek (1987) describes hypnosis as "an altered state of consciousness that occurs on a continuum of awareness" (p. 3). According to Spiegel and Spiegel (1978), the trance is a wakeful dissociative state of intense focal awareness that maximizes involvement with one sensory precept at a time. It can occur quite naturally and spontaneously in its most simple form. Many a person has found themselves suddenly at their destination not remembering having passed familiar landmarks to get there. However, some level of awareness had to be present in order to turn at the desired intersections and to stop at stop lights, etc. This type of trance-like state is synonymous with the hypnotic state characterized by a minimal amount of motor functioning. A trance can be recognized by the individual's glossy-eyed stare, lack of mobility, and nonresponsiveness to external stimuli. A person in a trance state is more receptive to suggestion. Hypnosis is considered a therapeutic tool but

not a therapeutic end in itself. As a method of treatment, hypnosis facilitates a number of different treatment modalities and is utilized in conjunction with other approaches to alter psychophysiological states, promote understandings and allow for creative problem solving (Mott, 1981). Therapists place their clients into a trance where they can use the subconscious portion of the mind. It is referred to by some in the field, as "expanding the frame of reference." Most hypnotists agree that hypnosis is contingent upon the ability to imagine. The induction instructions given by therapists using hypnosis are often identical to those given by therapists using guided imagery.

Sakell (1985) describes two types of hypnosis as the traditional and Ericksonian methods. The traditional method allows the therapist to assume an authoritarian role and make suggestions to the client. One authoritarian method has the client relax certain parts of the body one by one until completely relaxed. In Ericksonian hypnosis, the therapist uses a naturalistic approach, puts the client in a trance with individualized methods using phantasy, negative hallucination and arm levitation. In the trance state, the client focuses attention inwardly on one subject excluding all other stimuli. A therapist can give the client the proper contacts to certain memory and the person can provide extensive details of that memory. The authoritarian hypnotist is more like the all knowing shaman than the more

permissive educational format employed by those using guided imagery.

In the material presented by Araos (1983) on the uses of hypnotic techniques used with oncology patients, hypnosis is regarded as an adjuvant, supporting part of the cancer patient's treatment rather than a treatment for cancer eradication. He points out that there is no "scientific" evidence that hypnosis reduces the size of a tumor. Others disagree. Hall (1982), Achterberg (1985), and others believe that imagery/hypnosis strengthens the immune system and can increase white cell count as well as increase or decrease body organ size. Araoz identifies four uses of hypnotic techniques when used for the control of pain - analgesia, modification of painful stimuli, displacement, and dissociation. Bresler (1979) and Barber (1982) present very detailed material concerning hypnosis and pain control. Barber (1982) lists four basic methods for the management of pain:

- 1) Analgesia - Here one allows the mind to designate a healing hand. This hand is made to feel extremely comfortable and warm (or cool). It is then placed in the area where pain is felt. Several tries at this technique are usually needed before obtaining relief. The patient is asked to rate his pain on a 0-10 scale both before and after the exercise.

Glove anesthesia has been described by Barber, 1982;

Bresler, 1979; Kroger, 1976; and Sacerdote, 1982. This technique produces numbness in one hand, then transfers the numbness to the affected area. Kroger and Bresler describe this as a two step imagery exercise in which one first learns to develop feelings of numbness in a hand and then to transfer that feeling of numbness from the hand to any body part that hurts by placing the numb hand over the painful area. It is a symptomatic technique that reduces the physical symptoms of pain without concern for its cause. It can be either a useful alternative to or additive to analgesic medications. Bresler, Siegel and Simontons provide tape recordings of all the exercises used in their books.

Another analgesia method is to lead the hypnotized patient to a "growing" sensation of comfort both in intensity and in place, so that whatever minimal comfort the patient experiences (from exhaling for instance) begins to grow and expand.

2) Modification of painful stimuli. Clients are asked to describe the sensation of their pain. Then substitution of the painful sensation by a different less painful sensation can frequently enable the patient to tolerate some persistent feeling in the area but not to suffer from it (Barber, 1982, p. 147). If the pain is described as burning, the client is asked to imagine a cooling breeze or a shower slowly extinguishing the burning. If the pain is

stabbing, a tolerable vibration may be substituted. A gripping knot-like sensation can be substituted with the vision of a knot gently loosening up or undoing a sash or neck tie. Sharp knife or razor like pain can be visualized as becoming a smooth object such as a spoon. It is the therapists job to be creative in identifying the images that make sense to the client.

3) Displacement of pain is another technique of hypnosis. Patients often feel they are helpless when experiencing pain. They can learn to displace the painful sensation to other areas of their bodies and thereby control the pain. If the client/patient sees their pain as waves, the idea of waves of an ocean or lake can be used. The waves can increase and reach other parts of the body or even move outside the body such as down the arm and out through the finger tips.

4) Dissociation of the pain can be learned in a vivid goal directed day dream that enables the person to be psychologically in a different place or in a different time in their lives. This may be a healthy escape when faced with a painful treatment or procedure.

The actual fear of cancer and not receiving treatment may make the client hold onto the pain. Barber's suggestion to help the patient/client become aware of the "personality part in you responsible for your pain" is open to criticism, especially when he uses this approach when hypnotic

techniques are not effective. It is his premise that if patients can fake pain then they can fake non-pain. He takes the authoritarian stance that anyone can be hypnotized and does not possess an unconditional regard for the patient.

Hypnosis during cancer therapy provides the physical presence of a concerned and focused other person which, according to LeShan (1977), is a basic need of the cancer patient.

Hypnotherapy is frequently used for anticipatory nausea and/or treatment induced nausea when the client is receiving chemotherapeutic drugs. Nursing appears to have contributed to most of the literature in this facet of treatment. Since nurses are more likely to be giving the drug treatment to the client, it is their involvement that is more likely at the given time. Anticipatory nausea is best conceptualized as a classically conditioned response which may occur several days or several hours prior to a treatment. Redd, Rosenberger, and Hendler (1983) have found that hypnosis is particularly effective in controlling anticipatory nausea and vomiting and less effective in controlling the side effects of treatment.

Hoffman (1982) used a hypnotic treatment employing systematic desensitization to alleviate anticipatory nausea and vomiting in a middle-aged man undergoing chemotherapy for Hodgkins disease. After the fourth session, the client

was relieved of all nauseous discomfort associated with his treatment. Hoffman discusses all four sessions. The first session was devoted to induction into the hypnotic trance with deepening of the relaxation and comfort levels through deep breathing and listening to the therapists. The second session included all the senses in an excursion through a hierarchy of discomfort arousing scenes from being at home preparing for the clinic visit to the actual stick of the needle initiating the chemotherapy. Imaginal scenes were presented progressively, beginning with a more tolerable scene and ending with a less tolerable more uncomfortable scene. Each scene was presented twice and was followed by renewed suggestions to increase ease and well-being before progressing to the next scene. One of the hypnotic suggestions presented was that the client end by relating to a feeling of quiet soothing warmth in the stomach. Hoffman's third and fourth sessions consisted of hypnotic induction followed by repetition and expansion of the scenes for desensitization. His sessions with clients lasted approximately 30 minutes. His instructions for arousal remained the same in each session. The client was always given permission to linger awhile in the trance, but to awaken fully comfortable and refreshed when he was ready.

Having used this method to control the patient's uncomfortable symptoms, Hoffman found that the anticipatory emesis ceased completely after the second session. By the

end of the week, the client's wife reported that her husband was able to eat a full meal without discomfort even following the administration of chemotherapy. His report of the successful treatment using a systematic desensitization paradigm incorporated into hypnosis can be effective in establishing a control over anticipatory nausea and emesis.

In contrast to Hoffman's incorporation of desensitization with hypnosis, Redd et al. (1982) used hypnosis alone. After those sessions where hypnosis was not used, Redd's subjects all reverted back to the nausea with emesis.

Rosenberg (1983) provides similar suggestions in his annotated transcripts of induction technique, trance deepening, guided imagery, time distortion, post-hypnotic suggestions and reorientation to one's surroundings. He concludes that

imagery during hypnosis can stimulate beneficial physiological and psychological effects for the cancer patient, especially when undergoing surgery, radiation, and/or chemotherapy. Imagery is used to create a playground for the patient and therapist to meet, interact and gain perspective and control on the current and future 'crisis' of cancer (p. 127).

Some surgeons have become aware of mind/body continuum and have begun to "test the waters" of involvement with patients anesthetized in the operating room. A brief research report in the Lancet suggests that anesthetized patients who hear comforting suggestions during surgery may recover more quickly. The study done with a group of women

who had hysterectomies were played a tape during surgery that had suggestions like "You will not feel sick, you will not have any pain." while a similar group was played a blank tape. The woman did not know which group they were in, however, after surgery, the women who were played the suggestion tape had better recoveries. Also, almost all the women in the suggestion group guessed that they had heard the tape while under anesthesia, though they could not remember the content.

Some surgeons are now using music in the operating room to aid relaxation during anesthesia while others talk to their anesthetized patients to help them relax. B. Siegel, M.D., a surgeon in New Haven, Connecticut relates having had a patient who, before becoming disconnected from the machines in the operating room, began to develop a life threatening arrhythmia. Dr. Siegel moved to the head of the table and began giving the still anesthetized patient suggestions for relaxing his blood vessels and decreasing spasms in his heart. Without medication, the patient reverted back to a normal EKG pattern. Perhaps in time, other M.D.'s will accept the reality of the body/mind connection without fear of the unknown and see their role as more inclusive to benefit the whole patient.

The benefits of hypnosis can be summarized as overlapping and interlocking. Hypnosis is effective in assisting the patient to experience some relaxed states

thereby lower anxiety, alter moods, reduce perceived pain and distress of symptoms. The deep quiet allows healing to take place. Hypnosis is very helpful in reducing symptoms of the disease and painful side effects of treatments i.e., pain, nausea, insomnia, and loss of appetite. Perhaps most important, hypnosis is helpful in increasing one's sense of self control.

Frequently the patient's personality includes a basic attitude that he is at the mercy of others. It is a commonly held belief of cancer patients that they are helpless and hopeless victims of their disease. With continued work in this area, he begins to believe that he has the ability to say no to others and yes to his own control. The ability to control what happens to him allows him to fight for his life.

This has a snowballing effect in raising his self image and mobilizing his motivation in participating in his treatment. Hypnosis has also proven helpful in assisting those involved in analytical psychotherapy. For psychotherapists, the major difference in treating cancer patients is the life-threatening nature of the situation and the need to produce real changes in rapid succession over a relatively short period of time (LeShan, 1977; Newton, 1982). The overall result is a hope for significant improvement in the quality of remaining life.

Hypnosis Versus Relaxation and Imagery Techniques

The stated goals and procedures differ among these frameworks, (hypnosis, relaxation and imagery) although not markedly. All may evoke an altered state of consciousness and each has the potential for producing a trance-like

state.

Procedures of induction of the trance state are particularly emphasized in traditional hypnosis and less emphasized in relaxation or imagery techniques. Hypnosis utilizes both relaxation and imagery in the induction procedure, but neither is necessary for the individual to be either suggestible or to enter a trance. Suggestion, which is used in all of the procedures, is most often associated with hypnosis and is utilized consciously and specifically by the therapist. Many also contend that hypnosis purposefully works toward creating a deeper altered state of consciousness where usual superego functions are temporarily suspended. Relaxation, in contrast, focuses on a physiological progressive softening of muscles; imagery utilizes and depends on mental processes; each, however, may be utilized to promote the other (Zahourek, 1985, p. 5).

True scientific evidence in the credibility of the use of hypnosis, relaxation and imagery is generally lacking in the literature. However, the testimonials of patients and therapists indicate that such an approach has proven beneficial to some people with cancer who use this as a coping measure while working to survive their illness. One of the extremely important aspects of feeling better involves the complex structure of inner perception, self-esteem, and in general, the inner self-talk generated by beliefs, expectations, and fears (Araoz, 1983). The differences among techniques are few and more imagined than real but can enlighten the practitioner when choosing words to use with a client. For example, if a client is anxious about trying hypnosis, use of the term relaxation or imagery might be more acceptable. If hypnosis, relaxation or imagery techniques can help reduce tension, pain, and the

side effects of treatments or make these more tolerable and also enhance self-esteem, it can then be viewed as a humane method of treatment with or without scientific evidence. The generally stated goal is to discharge depression, hopelessness and helplessness by helping the patient/client feel in co-charge of their survival. Aranoz points out that many traditional therapists feel uncomfortable working with the medically ill person since they are trained to analyze the psychological causes of symptom behavior, understand those causes and then attempt to change behaviors. Many of the chemical treatments for cancer have expected side effects non-psychological in nature. The challenge for oncotherapists is to determine the usual from the exaggerated.

Other Counseling Situations

Employment Counseling

Diagnosis of cancer does not take place at a fixed interval after the onset of malignant growth. There are those with advanced cancer at the time a diagnosis is made, while others progress more slowly to and through the advanced stage. This is because some cancer cells grow faster than others and therefore some terminally ill cancer patients die at different rates. It is felt by some investigators that this variance is influenced by psychosocial differences (Worden, Johnston & Harrison, 1974).

The level of disability at the time of diagnosis will also vary. There are those who are employed and quite functional in the beginning stages of multiple metastasis while others are bedridden and in need of extensive care.

It is for this reason that counseling for some diagnosed cancer patients may first be needed at the place of employment. The individual may be referred to an Employee Assistance Program due to an increased number of used sick days for cancer treatments. In recent years, counseling in an Employee Assistance Program has been mainly funded for alcohol and drug abuse with much less money and effort spent for those with projected increased disability of various disease states. There has been nothing found in the research literature specific to counseling cancer patients in the work place. This may be an area needing further investigation.

It is an important and strong need to keep the cancer patient as functional as possible for as long as possible. Employment may allow the person to have medical insurance coverage, and in some places, provisions for disability. Work may also be one means of keeping one's self worth.

Robert J. McKenna, M.D., President of the American Cancer Society, has said,

If a patient does not return to work after cancer treatment, industry will lose a much needed worker, government loses taxes and potentially, an additional family is placed on welfare rolls. The dilemma ... is a joint responsibility of all society (Mellette, 1986, p. 4).

The problems, worries and needs of those still employed, fall into very broad categories, including a need for financial help, and assistance with some work tasks, threatened independence and low self esteem. There is the potential need for medical and/or mental health counseling. Counseling may be limited to one or two short term needs at the work place with referrals made for follow through elsewhere. Some cancer patients choose therefore to have their emotional counseling done away from the place of employment and seek out counselors in private practice when this is financially feasible.

The Rehabilitation Act of 1973, section 503, classifies cancer as a disability and any employer doing business with the Federal Government must uphold the non-discrimination laws. At the Western States Conference on Cancer Rehabilitation, March 1982 in Northern California, J. Barofsky, Ph.D. addressed the issue of job discrimination and related it to a measure of social death for the cancer patient. He pointed out that sometimes the disadvantage of the disabled person is not necessarily in their ability to perform the job but rather in their ability to gain access to the job or in being accommodated to the job.

Despite the laws, employment covert discrimination runs high for those still able to work. Due to required chemotherapy and/or radiation, work schedules may need to be adjusted or number of hours worked may need to be

temporarily reduced. Such needed alterations are commonly denied the person with cancer and some are asked to leave their jobs "for their health sake". The counselor in the E.A.P. may need to intercede for the patient to get these needs met and help them to still maintain a job. Problems of discrimination related to coworker attitudes are most notably that of hostility. Common examples are mimicry of the laryngectomy patient and jokes and snide remarks about ostomy patients and those with alopecia. In addition, a fear still exists among many that cancer is contagious. Patients have shared that the use of the drinking water fountain was discouraged; use of disposable cups, plates and eating utensils were encouraged. The cancer diagnosis may be a scapegoat, and the employee may suddenly be the victim of multiple unfounded criticisms leading to job loss. Some employers tend to behave without tact or empathy as they isolate and/or reject one with cancer. Education of such persons is obviously needed, but not always accepted.

Hospitals, as employers, are notoriously inflexible concerning days absent due to illness of any sort. One North suburban Chicago hospital permits only six days off total per year for illness before firing an employee. Some inner city hospitals are more lenient. One such institution allows five instances of illness, rather than days, before a warning is given, with dismissal coming with the sixth instance of absence due to illness. Is it any wonder then

that fears and anxieties increase for some during an already difficult time in their lives. Each day may bring new discouragements.

In the event that a cancer victim does lose his job, a second grief process may ensue coupled, but not in unison with the grief of loss of health. Loss of a job resounds as a crisis. Frequently the person suffers this alone. Once out of the work environment and without financial resources, a counseling recourse may no longer be available or affordable. Their energy level for fighting the system may be quite low. The outpatient oncology nurse and/or hospital social worker may be that part of the patient's network most likely to assist their client with the intense bombardment of emotions.

Data collected by the Human Resources Research Organization in which the Medical College of Virginia and other institutions participated, about 6% of the employers interviewed agreed that "cancer is usually a reason for disqualifying an applicant." One employer stated categorically that his company would not hire a known cancer patient. On the other hand, nearly half of those interviewed thought cancer had a lower risk than heart disease.

For those persons living on the East Coast, an organization called Cancer Care, Inc. is a service agency operating in metropolitan New York, New Jersey and

Connecticut, and also runs a nationwide consulting and referral service for those with job problems. This organization relates that cancer patients face economic assaults such as demotion, denial of promotion or having to relinquish a group health insurance as the price of keeping a job. Psychological abuses are more difficult to prove but exist from the extreme of being isolated, shunned and teased to being treated with excessive concern.

Francis Feldman, Ph.D., a California social worker conducted a five year study of employment and cancer health history using a random selection from the Los Angeles County's tumor registry. Her study revealed that half of those in white collar work and 84% of the blue collar workers reported problems on the job because of their illness.

It is a heavy burden to fight such a disease as cancer and the added insult of job loss or threat of loss makes fighting the disease more difficult. With the increase in anxiety and hopelessness that such a situation creates, symptoms may be exacerbated and no longer as easily controlled. In the Oscar-winning film, *Terms of Endearment*, the person with cancer had the chance to be touchingly brave til death. Back in the real world, there is a different demand on bravery.

Cancer patients indeed can at times passively or indirectly contribute to their own discrimination. They may

accept the suggestion of an employer to voluntarily terminate a job because of how they have learned to respond to discriminatory experiences, or because they lack energy of motivation, interest or satisfaction with the current job, or because of anticipated coworker response (e.g. to a colostomy or facial surgical deformity). Barofsky (1982) points out that some of the plus and minus attitudes of the cancer patient may be acquired as the person learns to be a cancer patient, learns to accept altered body image and learns to accept his mortality. But, how does he learn these?

It is evidenced by the lack of literature that while issues of job discrimination and insurance problems are addressed, the actual counseling of the advanced cancer patient for continued employment for as long as is reasonably feasible is still a voided area. At the present time, it appears that these individuals are being referred to a wide variety of agencies that provide only information and that more emotionally charged issues are being avoided.

In one study done prior to 1970, both the MMPI and Rorschach test were used as tools with clients having cancer and control clients. The results suggested that clients with fast developing disease are more defensive and overly controlled than clients with slowly developing malignancies. Persons with rapidly progressing cancer showed an inability to decrease their anxiety levels. Instead, these persons

presented a polite, apologetic, almost painful acquiescence to their illness. This was contrasted with the more expressive, sometimes bizarre, personalities of those clients who responded well to treatment with long remissions and a long survival (Blumberg, 1954) in Matje (1984, p. 400).

Group Intervention

Does group counseling with cancer patients work? If so, how does it work? The group approach to counseling has been used effectively for the psychological intervention with cancer patients and is used in a multiplicity of circumstances, settings and styles. In searching the literature for kinds of groups available to adult cancer patients, those most often mentioned are 1) couple counseling for those with sexual related cancers and 2) support groups, ranging from general support for any kind of cancer to specialized mutual support groups for specific types of cancer, mainly breast cancer, ostomies and leukemia. There is an embarrassing limited amount of literature concerning a more intense approach namely, group psychotherapy. Some of the very early literature of the late 1960's and early 1970's contains reference to group psychotherapy based on various psychological theory approaches as Gestalt analysis and Rational Emotive Therapy. The trend change over the past 15-20 years of interchanging theory approaches may be due to changes in society from the

rigid, formal and clandestine to the more relaxed, informal, and openness of the present day. Also, the emergence of support groups vs individual or group psychotherapy, may be economically more feasible for those whose finances have been exhausted on medical diagnosis and treatments. A great deal of emphasis is now placed on education and prevention which involves a relinquishing of sole authority by primary care givers with a sharing of knowledge as well as feelings between patient-physician and patient-patient. Schag and Heinrich (1989) point out that seeking information is a useful coping response, that a group can provide.

Group size tends to vary according to the type of group. Several writers agree that a group size should be limited to 5-7 patients (Corder & Anders, 1974; Kelly & Ashby, 1979; Yalom & Greaves, 1977). More intense involvement can be expected with a small group. There is also agreement concerning the pre-screening of members to exclude those individuals who are utilizing massive denial. It is acknowledged that denial is readily evident and appropriate in cancer care groups, however, profound denial can impede the process entirely. Patients who need denial to such a great extent would probably not benefit by revealing their inner feelings in a group setting.

Group leadership is a central issue which is often dealt with by relying upon a multidisciplinary approach and is often dependent upon the setting. In a military setting,

a chaplain may be the group leader (Corder & Anders, 1974) while in a hospital out-patient department, a psychiatric or oncology nurse may co-lead with a social worker (Kelly & Ashby, 1979). At religiously affiliated hospitals, a chaplain is generally appointed as leader or co-leader. Wellisch (1981) agrees that a team approach utilizing a combination of medical and mental health professionals provides a good balance. It is generally agreed not to include the primary physician as their presence might inhibit discussions of doctor-patient relationships. In addition, if the discussions center primarily on medical treatment, as frequently happens when a physician is in attendance, their presence might reduce the potential for psychological themes to emerge and develop.

The Yalom/Greaves (1977) paper demonstrated that resistance in groups can be effectively managed if the leaders are very skilled and experienced and have a solid grasp of countertransference issues.

Perhaps, given the almost overwhelming resistances described in unstructured group settings with very sick cancer patients, group therapy should only be employed with very ill or advanced patients by very senior therapists. For less ill patients, group therapy combined with educational formats seems a highly viable approach (Wellisch, 1981 in Prokop and Bradley, p. 230).

Why Do Cancer Patients Attend Groups

Cancer patients utilize groups for a variety of reasons. A formalized group may provide a reliable relief from bidirectional isolation experienced in the disease.

The group may facilitate the discussion of how to live with an illness associated with increasing pain, weakness and loss of control, strained relationships with spouse and children, financial hardships, difficulty in communicating with doctors and ultimately, underlying fears about dying. Psychologically based interventions--such as communication and assertion skills training in conjunction with stress management, relaxation, problem-solving and cognitive coping --can be helpful in improving patient-physician communication and anxiety reduction. Gordon et al. (1980), Heinrich and Schag (1985, 1989), Spiegel, Bloom and Yalom (1981), Weisman, Worden and Sobel (1980) have all concluded in their research that these techniques are useful and effective with cancer patients.

The relationship between anxiety in medical situations and communication skills is a particularly interesting and important finding. We do not know whether the anxiety is a consequence of a patient's inability to communicate effectively with physicians and other health care providers or whether the anxiety makes it more difficult to communicate effectively (Schag & Heinrich, 1989, p. 25).

In a group setting, patients and leaders can share and learn from each other what helps and what hinders communication in certain situations and how to handle the corresponding anxiety. Untreated, high anxiety can lead to a variety of problems including increased psychological morbidity (Gill, 1984), decreased quality of life (Wellisch, 1984) impaired work performance (Masur, 1981), and missed medical appointments as well as failure to complete potentially

curative chemotherapy and radiation therapies (Masur, 1981). studies done by Herberman and Ortaldo (1981), Locke et al. (1984), and Riley (1981) reveals that high anxiety may interfere with both immune function and survival; hence, the importance of dealing with this issue in a group.

The Setting

The setting of cancer counseling groups may be in oncology clinics, on oncology units, in departments of psychology, psychiatry or pastoral care; some are also held in rented halls or university/hospital conference rooms. There may be times when, for convenience, meetings are held in a group leader or patient's home. The key ingredient for success in group therapy with cancer patients is preparation. With adequate preparation, the setting becomes inconsequential.

Following more of an educational model, Schwartz (1977) and Ferlic et al. (1979) discuss their time limited programs that last several weeks. Each session is structured to last two hours and contains films and video tapes followed by discussion groups or combined lecture and discussion groups. Wellisch notes that where discussion is limited or highly structured, patients can utilize this to a greater degree with less fear and denial.

Whitman, Gustafason and Coleman (1979) observed the reliance on the rigid use of containment to bind high levels of anxiety. They also noted that where patients with cancer

in differing stages of progression are grouped together, patterns of defenses and patterns of ability to communicate may be vastly different. Yalom and Greaves (1977) solved this problem by deliberately structuring their group to include only end stage cancer patients. Other investigators have also seen a need to group patients according to progression of disease. Thus, there are groups designed only for the newly diagnosed, while others are for those in the living/dying stage. Some groups are limited to those receiving radiation or chemotherapy while others are for patients with various body organ involvement i.e., breast, colon, or prostate.

The issue of groups based around a particular cancer diagnosis versus those with a potpourri of types of cancer is also discussed in the literature. It has been noted by Wellisch (1981) that the unitary diagnosis group appears to go into less depth, but tends to be useful and bearable to more patients.

Patients generally enter a group by self-referral or by referral from various cancer organizations. Some physicians hesitate to refer patients to any group since they fear that if death is discussed, it could be unsettling for their patients. This tends to be more their own instability than that of their patients. Yalom and Greaves (1977) recollect that when therapists considered certain topics too threatening for patients to discuss, they were ultimately

protecting themselves. Anxiety, as a part of every day living, reaches its peaks and valleys.

Victor Frankl once suggested that Boyle's law of gaseous expansion in a physical space could be applied to anxiety, in that anxiety expands to fill any space offered to it. Many people who are relatively unburdened find that trivial anxiety fills their life space completely. Thus, the absolute amount of anxiety in the dying patient is often no greater than that of patients facing a number of other life concerns. It seems we get used to anything, even to dying (Yalom & Greaves, p. 399).

Goals and Issues

The goals for groups range from adjustment to physical limitations, to knowledge about rehabilitative processes and the use of prosthesis, meditating and visualizing away cancer to discussions of issues of terminal illness, death and dying (Spiegel, 1981). At times, the group may provide a type of desensitization experience as patients approach and palpate the most frightening issues. Groups can be both supportive and informative.

The goals proposed by Paulen and Kuenstler (1978) for their patient/family support group was twofold:

- 1) to encourage people to express feelings and concerns about living with cancer and its treatment, and
- 2) to facilitate mutual support among people who are facing similar problems. They have made no attempt to conduct group psychotherapy.

Issues that may present as discussion in the group may focus around seasons of survival as described by Hoffman (1989). The first season is "acute survival" that begins at

diagnosis and is dominated by medical treatment. This season involves much energy in the variety of treatment approaches suggested, experienced or rejected. The second season is the "extended survival" stage. It is here that the person may enter remission, perhaps once or perhaps several times. The third season is referred to as a curative but cautious stage when hope is greatest; while the fourth season is more diabolical, evolving in either permanent cure or recurrence of illness with decline.

A very real issue confronting anyone with an illness is how one will pay for it. When the person with cancer is their own sole economic supporter, loss of employment or even retaining part-time employment can lead to loss of health and life insurance, a most devastating impact.

"Without money, no one cares anymore" may be more real than imagined. The need to know how to obtain necessary resources becomes "prime time" and a major focus that results in great anxiety and much energy expenditure. If family members are available and willing to become involved, part of the burden can be lifted.

Overall Advantages

The advantages that groups provide include 1) using group members as role models for each other, and 2) members can explore new resolutions to old problems and increase their repertoire of effective coping skills. Members also benefit from helping each other and gain a sense of well

being and self worth which helps reduce the feeling of powerlessness and uselessness. This active role of giving and receiving is contrasted with individual counseling where the counselee can become a passive recipient. Participation in a group with others who have encountered the same life-threatening conditions provide a sense of community.

Spiegel supports Gordon et al. view that providing support in a group seems to have several advantages over individual counseling strategies. Spiegel also reviews Gordon et al. work reporting few significant differences between a control group and cancer patients given an individual psychosocial intervention. This contrasts with the reports of group work done by Ferlic et al. (1979) and Spiegel et al. (1981)--two reports of significant treatment control differences using group approaches with cancer patients.

Spiegel (1981) points out that there have been few systematic studies of these group procedures. Ferlic et al.'s research with a group that offered weekly treatment in a hospital setting seemed better on a variety of measures than a control group of cancer patients not offered such an intervention. However, they reported no follow-up on the patients studied.

The research study conducted by Spiegel, Bloom and Yalom (1981) gained its incentive from skepticism of the medical community about the efficacy of psychological approaches to oncological illness. They conducted a one

year randomized prospective study on the impact of supportive group interventions for metastatic cancer patients. The patients involved in the study had documented metastasis from a primary carcinoma of the breast. The co-conductor of the group included a psychiatrist, social worker and a counselor who herself had had bilateral mastectomies and whose cancer was in remission. The patients in this group were given a battery of tests designed to assess mood disturbances; phobias, self-esteem, coping strategies, understanding of illness, family environment, experience of pain and communication with their physician. These tests were given an entry into the study and at four month intervals throughout the year. It was concluded that the treated group showed less mood disturbance, were less fatigued, anxious, phobic and confused than their control counterparts. They also tended to suffer less pain. This data indicates that if left untreated, there is a general emotional downhill course during this phase of the illness.

Spiegel (1981) has identified ten themes that emerge and illustrate mechanisms underlying the effectiveness of group interventions with cancer patients. These include 1) mutual support, 2) living in the face of dying, 3) developing a life project, 4) realigning social networks, 5) working through doctor-patient problems, 6) detoxifying dying, 7) focusing on central life issues, 8) families, 9)

pain control, and 10) countering isolation. In "Group Support for Patients With Metastatic Disease" (1981), Spiegel, Bloom and Yalom note that the isolation experienced by the advanced stage cancer patient, can be "bidirectional". Cancer patients are frequently reluctant to burden family and friends with their health problems and morbid preoccupations. On the other hand, their healthy counterparts, in subtle but unmistakable ways, distance themselves from those who are ill. The support group is able to counteract these sources of isolation. Group members are encouraged to voice morbid concerns which "become a common bond" rather than a cause of isolation. Members and leaders offer one another a sense of presence. To keep members from feeling abandoned when too ill to attend the group meeting, telephone contact is kept. At times, group meetings are held in the residence of a home-bound member.

A group that is research focused provides opportunities for mutual as well as professional help and an avenue for addressing the personal concerns of medical management for oncologic illness. Such groups tend to be more structured than some of the mutual self-help groups not under research study.

The research paper presented by Ferlic et al. (1979) reveals that group counseling resulted in a significant increase in self concept. However, a six month follow up

testing indicated lower scores on the Self Concept Questionnaire. As cancer progresses, there is generally a tendency to worry and be nervous; there can be feelings of bitterness and a tendency to withdraw and feel out of control of life situations. Derogatis et al. (1979) reported that patients with metastatic breast cancer who tended to survive more than one year from the onset of chemotherapy were more distressed, anxious, alienated and depressed and more inclined to express their dysphoria than those who survived less than one year. Long term survivors have been perceived by their physicians as generally being less well adjusted and more hostile. There is an understandable impatience of never being able to be well. Ongoing provision of mutual support or self-help groups seems essential for dealing with these feelings if there is no close associate to provide this comfort.

The "how to" process of establishing/forming a cancer support group was discussed in the works of Wood et al. (1978), Paulen and Kuentler (1978), Herzoff (1979), and Barstow (1982). To join already established groups, local chapters of the American Cancer Society provide a resource pamphlet titled, "Pathfinders" that lists and describes cancer support groups in a given region. In addition, the newly formed National Coalition for Cancer Survivorship, 323 Eighth St. SW, Albuquerque, New Mexico 87102, is a national network and clearinghouse of many community support

programs. Clients are entitled to know what else is available for them.

The Chicago Unit of the American Cancer Society provides material on Oncology Support Groups in Chicago. The information is organized as follows:

- I. Patient and Family Support Groups - General
- II. Groups with a Special Focus
- III. Hospice
- IV. Bereavement
- V. Phone Lines
- VI. Information and Guidance - Agencies

Other chapters of the American Cancer Society no doubt provide a similar list of references. It should be noted that it takes a certain intensely perceived need to motivate an ill and perhaps disabled person to realign their social networks and seek help beyond supermarket acquaintances.

In the 1978 report by Woods et al., encouragement was given to maintain an ongoing strong support system. Telephone numbers and addresses were exchanged and if a member required hospitalization, other members visited. Many of the participants in the Woods et al. group were women who lived alone. They tended to respond to each others needs readily by providing transportation for each other to and from the meetings and even food when one participants welfare check was delayed. Group leaders utilize crisis intervention to mobilize members from such

potentially paralyzing situations (Herzog, 1979). Everyday problem situations for the normally healthy adult may be viewed as a crisis for an advanced cancer patient alone and without adequate financial or other resources. Crisis theory supports capitalizing on the existing strengths and healthy psychological defenses against anxiety. The adult terminally ill cancer client with multiple needs tends to benefit most when group leaders weave an eclectic conceptual framework with their varied skills, the basis of which is genuine caring. Thus the term "therapeutic group" is manifested and amplified.

Some researchers have sought to measure the concept of social support. In 1978 Murawski, Penman and Schmitt identified social support as "a protector factor buffering the effects of stressor factors in the etiology of disease. They cited a lack of an adequate instrument to measure social support as a serious problem for research on the effects of coping with disease. In the statement of Research Priorities for the 1980's, the American Nurses' Association (ANA) Commission on Nursing Research included social support networks as an example of personal and environmental determinants of wellness and health functioning that needs further study. Thus the quest began to study the concept of social support. By 1981, Norbeck began to study the globalness of social support and identified attachments in infancy as the prototypes and

precursors of supportive interactions in adulthood. She addressed a need for short term, intermediate and long term or continuous support as well as low, medium and high intensity of support required at different times. She identified high intensity as the support needed for acute stressors or illnesses. Later in 1981, Norbeck teamed with Lindsey and Carrieri to develop an instrument to measure social support. They recognized that social support is multidimensional and both functional and network properties are important. The results of their study indicates the need for additional normative data before using the instrument on the clinical population. While Norbeck, Lindsey and Carrieri were working on their instrument to study social support, Brandt and Weinert (1981) were developing a Personal Resource Questionnaire (PRQ) to identify areas in life when support could be perceived as needed.

In 1982, J. Peteet, a psychiatrist in Boston distinguished four principal meanings of support as comfort, strengthening, maintenance and advocacy and the clinical context where each would apply. Sarason et al. (1983) (psychologists) developed a social support questionnaire very similar to that of Norbeck, Lindsey and Carrieri (nurses); however, while each scored their questionnaires differently, both were focusing on the number of social supports in a person's life as well as the degree to which

each is personally satisfying. Since the Norbeck group included areas of loss in their questionnaire, this would make it more applicable to those persons experiencing terminal illness. Cobb (1976), McNett (1987), Irwin and Kramer (1988), and numerous other researchers recognize that social support appears to enhance effective coping. Hence the relationship of group therapy or therapeutic groups for the supportive needs of the advanced cancer patient and their struggle to cope.

And so, does group counseling with cancer patients really work? The answer is yes. In a 1979 study by Ferlic et al., the effect of a structured interdisciplinary group counseling program studied 30 newly diagnosed adult cancer patients with advanced cancer. These were compared with 30 patients who were not provided with group counseling. In this study, group counseling resulted in a significant improvement in patient perception and self concept. Ten years later (1989) D. Siegel, M.D. of Stanford University made an astonishing and long awaited report of a 10 year study of women with metastatic breast cancer and found that those who participated in a weekly support group survived almost twice as long as the control group which received the same aggressive oncologic treatment but no psychological intervention. What is surprising is that his study was accepted by and published in a medical journal - Lancet, October 14, 1989. At last there seems to be a meeting of

the minds between the psychological and medical fields.

Summary

The group approach is considered a common format for the intervention into the problems of patients with chronic illness. In a therapeutic group most members can be considered emotionally healthy individuals who are facing the crisis of illness. Intervention can focus on developing new coping strategies and providing support and education to respond in healthy ways. The group's structure, content and process may require different guidelines for the selection and training of group leaders than is true of a traditional psychotherapy group.

Herzoff (1979) states it most concisely when she contrasts the role of group therapists in psychotherapy groups vs therapeutic groups.

The role of a group psychotherapist working with patients with mental disorders requires knowledge of psychological development, defense mechanisms, psychiatric pathology, as well as knowledge of group processes. The role of a group leader or facilitator in a therapeutic group for cancer patients requires knowledge of their medical disease, knowledge of group principles and group dynamics, and a knowledge of specific resources and techniques to reduce stress and anxiety resulting from the patient's illness. Therefore the training for a group facilitator for cancer patients is different from that of a mental health professional doing group psychotherapy with psychiatric patients (p. 470).

A review of the literature on social support and help seeking reveals the complexity of the relationship. Health professionals agree that emotional support should be offered to cancer patients. They do not so easily agree on what

form such support should take. Models for providing this support have been traditional psychotherapy or counseling process. While some patients readily accept these models, others interpret the offer of either group or individual therapy as a deviant label in their dying. Those with this perspective do not wish to experience themselves as emotionally weak while their weak bodies deteriorate. Ergo, the development of self help mutual support groups or a reliance on family or close friends to provide help in the struggle of living. The roles of culture and level of education cannot be overlooked in the decision to join or not join a group and may be an area requiring further investigation.

Counseling Opportunities for Sexual Dysfunction

Pamphlets provided by the National Cancer Institute in Bethesda, Maryland, concerning sexual organ involvement have traditionally been factual in nature. Although recognition is given that there may be different emotional reactions to the diagnosis of these concerns, no advise is given beyond speaking with one's family and physician if in need of emotional support. However, a toll-free number for the Cancer Information Service is provided. It was not until 1988 that the American Cancer Society published individual booklets on "Sexuality and Cancer" for men and for women. These booklets scope the topics of a normal sex life, healthy sexual responses, strategies for dealing with sexual

problems, various myths and the availability of professional counseling help. A listing of resources such as books, tapes, and support groups that might be of interest to cancer patients, is also included. Due to the fact that the sexual revolution took place in the early 1960's, the detailed descriptive information provided in these two new booklets seems to have been a long time in coming. The medical community at large still tends to wait to talk about the impact that cancer may have on this area of body functioning until the patient voices questions or concerns. Some nurses continue to view sexuality as too private to talk about and a shameful breach of a patient's privacy when the topic is introduced. Hopefully the psychosocial effects of cancer addressed by Fisher (1983) and Rutherford (1988), the sexual assessment and counseling advise offered by MacElveen-Hoehn and McCorkle (1985) and the sexual adjustment questionnaires developed by Waterhouse and Metcalfe (1986), (all nurse authors) will somehow grant permission to those currently reluctant to consider such discussions. While it is the professional's responsibility to address the issue of sexual dysfunction and give it the respect and validity it deserves, Schover et al. (1984) point out that one type of clinician who should not be involved in sexual counseling is the person who is uncomfortable with the topic and tries to impose his or her values on the patient. Renshaw (1985) states that the

comfort of the doctor, nurse or therapist determines the comfort of the patient in this type of dialogue. Health care providers have to be truly non-judgmental toward their patients and might have to come to terms with their own sexuality as well as their own mortality.

A greater number of articles are now being published on the topic of sexuality and the cancer patient, but only a scant few have described empirical investigations or integrated approaches in the area of sexual functioning and cancer. Knapp and Berkowitz (1986) note that most studies are case reports and summaries of professional experiences and have not employed systematic methodology. They also note that in terms of research, sexual adjustment to gynecologic cancer has received more attention than any other form of adjustment. Differences in sexual functioning at the various stages of disease (initial diagnosis, cure of primary tumor, recurrence, and terminal phase) have not been documented. However, Silverfarb, Maurer, and Crouthamel (1980) found that recurrence of breast cancer caused a much greater emotional disturbance than did initial diagnosis or terminal stages of disease. In addition, Gotay (1984) reports that patients in the advanced stages of disease acknowledged more problems than did patients in early stage of disease.

The literature tends to pursue the multiple aspects of female cancers and resulting maladaptations more intensely

than for males. Some researchers have explained that it is a characteristic of women to be more accepting and open to discussions of sexuality and intimacy and a greater willingness to be involved in research studies. Physicians, nurses and social workers doing this research tend to be female, ergo the possibility of discrimination for their own sex. On the other hand, 1989 statistics of estimated cancer deaths by site indicate 66,100 female deaths from breast and genital cancers versus 29,400 male deaths from breast, prostate, testes and other genital male cancers (National Cancer Institute Surveillance, 1989). Funding for research tends to be more available for those cancers of greater incidence and therefore a more reasonable excuse for the greater number of studies concerning women.

In their search of the literature, covering 15 years, Beckham and Godding (1990) discovered the literature regarding sexual functioning of cancer patients has covered such areas as general assessment instruments, specific assessment instruments, dysfunction related to specific cancers and methods of surgical reconstruction. Only recently have some authors stressed the importance of assessing sexual pre and post treatment functioning of cancer patients (Golden, 1986, Renshaw, 1987) and counseling them about their sexual functioning (Stoudemire, 1985, Renshaw, 1987).

Sexual dysfunction in cancer patients is not restricted

to cancer of the genital reproductive organs. Breast cancer is one example where a patient's basic self-concept can feel threatened through distortions in body image and sexual identity. "Perhaps the most private scar left by cancer is the damage done to your view of yourself" (Schover, 1988, p. 26). Cancers that result in cosmetic changes frequently cause alterations in self image, especially when the face, head or neck are involved. Cancers of the lung, blood and gastrointestinal tract are reported to involve sexual disturbances due to general debilitation and dysphoria associated with the disease. The presence of a draining ostomy may preclude satisfying sexual intimacy if the patient feels physically repulsive or unattractive leaving the chance of effective functioning at a minimum. In addition, genitourinary cancers can make sexual intercourse impossible through damage to the primary organs or nerve supply.

Beckham and Godding (1990) recount that sexual functioning consists of a complex mixture of emotional, cognitive, behavioral and physiological phenomena and dysfunction can occur in any one or a combination of these and in any phase of the sexual response cycle. The same authors describe Kaplan's (1983) modification of Masters and Johnson's sexual response pattern into a three phase cycle: 1) a desire phase, consisting of fantasies and desire for sexual activity; 2) arousal phase characterized by penile

tumescence or vaginal lubrication; and 3) a release phase of orgasm followed by a refractory period. In addition to the psychological and organic factors that influence sexual functioning in the general population, cancer patients must deal with the effects of their disease and its treatment. Many treatments for cancer are associated with sexual disturbances. Derogatis and Kourlesis (1981) discuss possible ways in which cancer treatments can effect sexuality, among them, cytotoxic chemotherapies, radiation, and surgery all of which result in intense fatigue. "Psychological disorders concomitant with or in reaction to, the diagnosis and treatment of cancer can also cause sexual dysfunction usually as a result of loss of libido" (Derogatis & Kourlesis, 1981, p. 47).

Medical Concerns

Disorders in the desire phase of sexual response have not been researched for breast cancer patients (Anderson & Jochimsen, 1985). A decreased libido is common for patients owning prostatic cancer who are treated with chemotherapy and hormones (Balducci et al., 1988). "Drugs such as alkalating agents (chlorambucil, cyclophosphamide, busulfan, and melphalan cause gonadal dysfunction in both men and women" (Stoudemire, 1985). Balducci et al. suggest that impotence caused by cytotoxic chemotherapy may be a rare side effect of neurotoxic drugs such as the vinca alkaloids and platinum or it may present as an extreme form of depressed

libido. The drugs procarbazine, vinblastine and cytosine arabinoside are known to have sexual side effects due to their toxicity on the ovary and testes. The signs and symptoms of ovarian dysfunction do not occur during cytotoxic therapy but later, and the duration is variable, lasting a few months to three or more years. Women treated with these drugs experience decreased libido, vaginal epithelial atrophy, endometrial hypoplasia, amenorrhea and the vast array of menopausal symptoms. The risk of treatment-related amenorrhea and menopausal symptoms increase with the person's age. Men develop gynecomastia, impotence, decreased libido, and infertility (Balducci et al., 1988).

Ketoconazole used in high doses creates a therapeutic castration for the prostrate cancer patient with hormone responsive tumors, since it suppresses the synthesis of androsterone in the adrenal and testes. The end result is impotence related to loss of sexual drive (Trachtenberg & Pont, 1984).

It is possible that the level of desire may not lessen with illness and sexuality is definitely not limited by age. One author gives the example of a terminally ill elderly woman who had granted permission for students to interview her. When given a choice of whether she preferred men or women to interview her, she winked and said she preferred the young men of course.

Disorders of the arousal phase of sexual response are

described by breast cancer patients and reported by Gerard (1982) and Anderson and Jochimsen (1985). Men are not exempt and can experience erectile impotence as a result of cytotoxic chemotherapy, pelvic radiation or hormonal treatment for metastasis (Balducci et al., 1988). Before 1980, 85-100 percent of males admitted to total loss of erection after radical prostatectomy. Since 1980, the Walsh nerve-sparing procedure has reduced the incidence to 20-66 percent of men reporting this problem (Beckham & Godding, 1990). One researcher reported that the Walsh nerve-sparing procedure helped improve the problems of erection but did not improve problems of orgasm. Disorders of the release phase (orgasm) are uncommon in the literature on breast cancer patients.

While it is now widely recognized that cancer and its treatments can cause sexual dysfunction, resources regarding the kinds of counseling assistance rendered are much more scarce. Sexual counseling may include couples or individuals or individuals with significant others. During and following cancer therapy, patients are often faced with additional stress caused by fertility problems, physical discomfort, changes in body image, energy loss and changes in personal perspective. Cancer involving the sex organs may or may not result in disfigurement. However, resulting dysfunction in any of these areas may lead to impaired self-esteem and psychological dysfunction with fears of sexual undesirability, anxiety in social situations and/or

resulting depression. Those persons with late stage cancers are frequently overwhelmed by weakness and debilitation resulting in yet another obstacle to sexual union.

It would be erroneous to think that every individual with cancer of the sex organs will require intense psychotherapy or long term counseling. However, adequate credibility of the changes that may result in a client's life as a result of this area of organ invasion requires more than menial recognition on the part of the care takers. If ever there were a need for teaching and sensitive sharing of feelings, it is with these clients. Anticipating questions and assessing the need for information while generally the role of the physician, may be more comfortably dealt with by others caring for the client. Therefore, referrals for counseling services may be made by various levels of personnel. For the person with advancing cancer, sex may be the least of their concerns, however, some clients may regard it as an essential need through all the stages of illness.

Wise (1978) and Beckham and Godding (1990) address the necessity of the physician counseling a patient with an incurable disease to be aware of the person's pre-illness sexual activity, general attitudes, present level of functioning and desires for sexual activity.

Glasgow, Halfin and Althausen (1987) also stress the importance of initiating a sexual history as a stepping

stone to counseling the person with perceived sexual maladaptations. Knowledge of the person's sexual behavior and attitudes before illness may reflect expectations of themselves and significant others during the various phases of illness. The sexual history also determines whether illness related and post-treatment sexual dysfunctions are related to the cancer and its treatment or might possibly be long standing problems. One's cultural and religious values may also be explored.

In general, couples who had a satisfying sexual relationship before cancer was diagnosed will be able to find satisfaction afterward, and couples whose relationships were troubled before illness will suffer greater disruption (p. 323).

However, they also point out that the crisis of illness may create a positive turning point to a previously troubled relationship. Glasgow, Halfin and Althausen prefer to meet with the patient's partner alone for any expression of concerns and later include them in further discussions.

Wise (1978) identifies the psychological consequences of the patient with advanced illness as 1) Regression. Any form of illness promotes regression and return to old modes of behavior (including sexual modes). In addition the terminally ill person who needs to depend on others and forfeit his autonomy may become hostile and demanding and thus prevent opportunities for sexual interaction with a partner. 2) Role changes may also be necessitated. The housewife with advanced breast cancer cannot be expected to

be as good a housekeeper or sexual partner as when healthy. In chronic or terminal illness, the averted expectation by others of a complete and full recovery may lead to the patient being blamed for his illness. The ensuing guilt or feelings of not being understood can compromise personal relationships and alter sexual communication. 3) Decreased self-esteem may result when a sense of shame or personal defeat decreases libido. 4) Limitation of activity is common. Those who are becoming weaker and terminally ill may be unable to deal with stress by physical outlets as in the past. New learning may need to take place regarding emotional, physical, sexual outlets. Failure to do so may lead to depression and sexual avoidance. Wise uses the above topics to form his treatment plan. In addition he points out the need for caretakers to understand how the patient is reacting to a fatal disease and recognize when denial, anger, depression and siltation are present. He also advocates a permissive attitude indicating that sexual urges and concerns even in severe illness are quite normal.

Waterhouse and Metcalfe (1986) reviewed several tools that are available in assessing sexuality that could be incorporated into sexual counseling specific for cancer patients. These include: Metcalfe's Sexual Interview Tool (1980) and the Sexual Function After Gynecologic Illness Scale (SFAGIS). The Sexual Interview Tool is concerned with changes in the client's sexual relationship, activity level

since surgery, and whether nurses discussed the potential impact of surgery on the client's sexuality. The SFAGIS, a 30 item self report scale, is useful only with gynecologic cancer patients. It provides information on the sexual activity of this specific cancer but does not measure changes in sexual functioning over time (p. 54).

In addition to these tools, a natural part of sexual counseling is the anatomical discussion and includes drawings, diagrams or models to explain various physiologic functions affected by the disease and its treatments. The message to convey is that impairment of various body functions need not preclude a satisfying sexual experience.

Patient Concerns

The emotional response to the experience of the terminal stage of illness are related to individual personalities, past experiences and current developmental stage. A never married young adult will differ from a middle aged women with young children who in turn will differ from a widowed elderly person living alone. The sexual and psychological issues an individual faces at these various stages of life are quite different from one another and can influence adjustment on many levels.

Some patients conclude that cancer in the genital area is a punishment for real or imagined sexual acts, extramarital affairs, abortions, rape, masturbation, incest or various contraceptive practices, and respond with shame

or guilt. In the bargaining stage, described by Kubler-Ross (1969), the person may vow to avoid all sexual activity in exchange for survival.

Loss of Libido

While depression is considered by some researchers as the triggering psychologic cause of loss of libido, other factors as drugs, anemia, anorexia, muscle atrophy or neurologic impairment causes weakness and disability leading to loss of libido in the advanced stages of illness. Changes in libido are frequently associated with cancer treatment which may disrupt the body's hormones. The chemotherapy for Hodgkins disease may cause ovarian failure with a resulting loss of sexual desire. A loss of libido is a common reaction to sexual dysfunctions of erectile or orgasmic failures. At times it may be difficult to determine the loss of sexual interest caused by advancing cancer and its treatment and the loss of interest that results from clinical depression. Advanced cancer patients dealing with their impending death may indeed become depressed as well.

Balducci et al. (1988) reviewed one research team that studied libidinal abnormalities among women receiving combination chemotherapy for Hodgkin's disease and found that most of the husbands had extramarital affairs within 12 months of onset of spouse's treatment. They attributed their infidelity to their wives' loss of sexual interest.

Changes in Body Image

There may be major or minor anatomic changes in physical appearance due to cancer treatment that may lead to negative feelings about one's body. A lowered self-esteem may lead to isolation decreasing availability for intimacy. Fear of how others will respond to one's altered appearance is a significant factor in emotional distress.

Removal of the breast or vulva need not compromise femininity. When these organs are regarded as diseased organs that threaten life, the compromise between life and death may make the loss more bearable. Removal of the vulva and related genitalia will result in changes in sensory perception and dyspareunia. Balducci et al. (1988) report that

30-70 percent of patients who undergo reconstructive surgery report the return of orgasmic sensations. These data underscore the importance of psychologic components in arousal and orgasm since vaginal reconstruction does not include reconstruction of the clitoris and the Grafenberg point, the normal mediators of sexual arousal (p. 163).

Resuming sexual activity as soon as possible after surgery may relieve the patient's anxiety, which in itself can exacerbate any sexual problems.

Schover et al. (1984) have remarked that patients should be encouraged to explore the sensations produced by noncoital touching and take a "wait and see" attitude toward erection and orgasm. The couple can be given the sensate-focus, touching exercises that sex therapists often

prescribe as a basis for a new way to enjoy sex. "It is crucial to convey the message that sexual pleasure and activity can continue if the patient wishes" (p. 71). For women without partners, self pleasure may be the only sexual outlet and a vulvectomy may be perceived as an irrevocable loss. This may or may not be important to those in advanced stages of illness.

Radiation

Fibrosis of tissue results from intracavity radiation leading to structures and dryness. Some patients continue to bleed following this treatment for vaginal, cervical and uterine cancers and may have fears concerning resumption of sexual activity. Continued support is needed with subliminal messages that sex can continue. Water based lubricants or estrogen creams may ease the discomforts felt with coitus. Men are especially effected by the cancers that damage primary organs or their neurovascular supply. Treatments of the cancer with radiation, cytotoxic agents or ablative surgery may in addition result in the sexual problem of sterility; therefore sperm banking needs to be discussed with the man who wishes to leave children for his spouse.

In his address to the Fourth National Conference on Cancer Nursing (1983) Pearsall comments on the research of Bullard et al. (1980) that 70% of their sample of cancer patients found sexual activity somewhat more or much more

important following diagnosis of their disease. In addition, 63% of the patients would have liked more information on the effects of cancer on their sexuality. Of those patients labeled by society as without partners (divorced, widowed, unmarried), 84% would be interested in more information on sexuality. Surveys conducted by Bullard indicate that the medical professional is unprepared to meet the need and readiness expressed by their patients. Sensing the reluctance of their physicians to approach the topic, some patients conclude that discussions are not wanted and that their disease is a punishment. Their illness then leads to dis-ease.

Persall (1983) defines sexual wellness as "the ability to relate intimately and responsibly with a partner of choice in a mutually pleasing manner, congruent with one's chosen lifestyle, resulting in a sense of fulfillment" (p. 81). He distinguishes between sexuality, sex, and sensuality and refers to sexuality as synonymous with self-esteem and the components of worthiness and sense of competency. Failure to offer sexual counseling tells patients that they are no longer viewed as sexual. Sex is generally a modality for expressing that sexuality and involves the stimulation of erotic zones leading to coitus. Sensuality refers more to the sending and receiving of pleasurable stimuli which may be spoken or nonspoken or may involve some behavior of sensitivity expressed by relating

intimately, i.e., kissing, hugging, lying close, touching, holding hands, or a special look. A feeling of caring and attraction is conveyed in a close relationship. Advanced cancer patients frequently experience a threat of abandonment through emotional withdrawal by their partners, families, and health care providers. Schain (1988) states, "Long after the desire or ability to have sexual intercourse has faded, the wish to be affectionate and intimate persists" (p. 28).

A study of affection by Leiber et al. (1976) also suggests that those persons diagnosed with advanced cancer, and whose desire for sexual intercourse decreased, developed an increased desire for nonsexual physical intimacy. This points out that cell disease does not interfere with all components of sex.

'Desire phase disorders' are typically the most apparent areas in need of intensive therapy for cancer patients. Real or feigned increase in desire by the cancer patient due to needs for closeness or as negotiation to keep the partner, are common as are decreases in desire due to feelings of isolation, distraction, fear, incompetence or unworthiness (Pearsall, 1983, p. 83).

An exploration of the individual's desire, interest, arousal, and excitement may expose and break through the fear of patient and partner regarding sexual feelings and allow a much needed intimacy at this time of their lives. To inquire about sexuality is to inquire about a natural life process while upholding the spiritual, moral, and ethical standards of the patient.

Some strategies offered by Pearsall (1988) for sexual counseling of the cancer patient include several utilized in other non-illness related counseling situations. Annon and Lazarus both have models for intervention in the area of sexual wellness. Annon (1976) refers to his as the "PLISSIT model". In this, P = permission giving; Li = limited information; SS = specific suggestions; IT = intensive treatment. Lazarus (1976) model of the BASIC ID is: B = behavioral assessment; A = affective state; S = sensation; I = imagery; C = cognition; I = interpersonal self-concept; D = drugs and other metabolic issues. Both of these models offer worthwhile guidelines for the counseling process with cancer patients. In addition, an "8-S" model of counseling has been followed at Sinai Hospital of Detroit. This involves security, specificity, seriousness, scientifically oriented, sensuous, social awareness, sensitivity and simplicity. The KISS theory prevails - "Keep It Simple Stupid" as a reminder to not get lost in complexity.

When the patient requires a more intense sex therapy, the treatment follows the behavior theorists model. Sexual Dysfunction Clinics, such as the one conducted by Dr. Domeena Renshaw, M.D. at Loyola University, and those at other large university affiliated medical centers provide this service to cancer patients and their partners on a referral basis.

It is interesting to note that Gideon and Taylor (1981)

saw a need to formulate a "Sexual Bill of Rights" applicable to the patient with advanced disease. It is as follows:

Sexual Bill of Rights

The dying person has the right to:

1. Be a sexual person, physically, emotionally, spiritually and socially.
2. Know that intercourse and sexuality are different phenomena.
3. Counseling either with sexual partner present or absent.
4. Be in charge of his or her own body.
5. Information that will help in accommodating physical changes occurring in the body.
6. State sexual needs and negotiate the meeting of those needs.
7. Confidentiality.
8. Forms of pleasuring other than intercourse.
9. Information regarding the use of physical aides to enhance physical sexual activities.
10. Express sexuality regardless of hospitalization or institutionalization.
11. Practice own sexual lifestyle, express sexual preference and sexual needs, and be respected as a person while doing so.
12. Risk self and partner's getting hurt.
13. Bear or father children within confines of full

understanding between two parents.

14. Communicate with own children regarding physical illness and sexual identity and growth.
15. Open communication with sexual partner and a communication system that allows for the expression of physical needs that might otherwise seem to be expressions of "negative feelings" (1981, p. 305).

putting this bill of rights into practice would require changing both the rules of some institutions and the attitudes of many personnel. The accommodation of visiting hours and the provision of privacy might be more easily changed.

Overview

Most cancer patients report a decline in sexual activity which may be disease or treatment related. Many of the sexual dysfunctions recognized by the medical profession are also among the concerns of the patient. While sexual adjustment research has been extensive, patients indicate that they desire more instruction than they receive. Many health care providers probably fail to deal with sexual issues, perhaps rationalizing that the patient will ask if he or she wants to know. Some may also feel too uncomfortable to inquire about or discuss the topic. The importance of a pre and post treatment sexual history is stressed. Ignoring these basic human issues may further

aggravate the patient's sense of loss with an ensuing depression complicating the diagnosis. In general, the literature shows a lack of empirical investigations or integrated approaches in the area of sexual functioning and cancer counseling. The studies conducted tend to be focused on female cancers, perhaps because their incidence of mortality is higher than for those of men.

CHAPTER IV

SUMMARY

This extensive review of the literature has explored the various psychological intervention methods used with adults in the advanced stage of cancer. Counselor preparation is discussed as a special need. It is generally recognized that few mental health providers feel comfortable or trained appropriately for working with clients who have chronic illness and limited life span. Given the special needs of these clients, oncotherapy and general psychotherapy are compared and contrasted. A basic assumption of oncotherapy is that once the therapist accepts a client, the client is never to be abandoned but followed until death, even given a lack of financial resources. General psychotherapy approaches probably must be altered to meet the needs of the cancer patient.

The roles of inheritance, stress, and personality are discussed as they contribute both to the development of the cancer syndrome as well as to the progression of disease. It is proposed that there is a need for an approach to therapy that will not contribute to the stress and loss already experienced by cancer clients. Although the role of

stress and its wearing effects on the immune system's ability to fight illness first emerged as a questionable enigma, it more recently has become an accepted phenomenon.

Besides the usual stresses encountered by healthy persons, the diagnosis and life with cancer adds yet another very profound burden. The clinging burden is never removed and relief does not come with winning the lottery, moving to a different town, obtaining a different spouse or taking a hot bath. There are those in the literature who profess that the way a person handles general stresses in their lives, is the way they will approach their stress of cancer. However, other stresses may be relieved by various actions taken such as attending exercises classes or rebuilding a home after a flood or fire. Physical outlets may not be possible in the advanced stages of disease when energy and finances are at low ebb. Other alternatives must be found. A strong social support system from family or outside support groups may serve to buffer the effects of crisis impact and its ramifications.

The question of what happens to a person's emotional life when enveloped by a cancerous illness can be approached by exploring the conventional and nonconventional methods of therapy available in the marketplace. The key to any of the oncotherapy approaches used lies in the ability to be supportive versus confrontive and to be exceptionally flexible in regards to time and location of sessions.

Sharing the client with other disciplines may be necessary and even paramount when the person is hospitalized. For example, when one is adapting Bresler's method of encouraging a client to speak to his pain, this action by the client may be viewed as hallucinatory behavior by those left uninformed. Avoidance or the use of unnecessary restraint or medication may follow.

Several traditional approaches to therapy and their application to work with cancer patients were reviewed. The traditional psychoanalytic approach places much emphasis on events of the past and has remained ill defined in the treatment of cancer patients. When it is the method of choice, it is often combined with mood altering drugs. Certain cancers are known to create a hormonal imbalance i.e. cancer of the pancreas, some brain, lung and gynecologic cancers. The use of analysis for these people may seem inappropriate. However, for some advanced cancer patients, the progressive dependence on others may regress the person to stages where conflict and unfinished business lurk. In this instance, a recalling of the past might grant greater comfort to the present. This approach is generally known to create stress and tends to be long term. If used, it may need to be abbreviated to meet client needs and must be coordinated with medical care.

The hopelessness and helplessness of advancing disease may lead to thoughts of suicide. Not all suicide attempts

are a cry for help. There are those who sincerely feel that suicide would be the most rational action to take. Maxwell (1980) and others agree that the documented suicide rate is low for cancer patients. However, suicide should be anticipated in those who are depressed and/or those who lack an adequate social support system.

The second major approach discussed was the Humanistic or Patient-Centered Rogerian method. In this approach, the client decides what problems he/she wants help to work on. One aim of this approach is to help the client develop an individuality to the greatest possible extent. A second aim of the therapist is to help the client relinquish emotional ties and may be more appropriate during the dying stage. The advanced but functioning cancer patient generally needs the support of others rather than attempting to sever relationships.

Since the cancer patient's life is filled with situational crises, the cognitive, crisis intervention model may be required on a frequent basis. Some crises can be predicted, as when painful procedures are required, when old symptoms re-occur, or when rehospitalization is necessary. Crisis intervention is based on the here and now with goals of realistic plans for the near future.

Behavioral therapy, a third traditional approach, tends to focus on the nagging fragmented problems of daily living with cancer. It encompasses many of the non-conventional

approaches of meditation, relaxation, imagery and hypnosis as adjuncts to medical therapy.

Cancer rehabilitation is intended to help people to function at their optimum. Unlike rehabilitation for diabetes or amputees, where the level of function is expected to improve over time, the cancer patients' function are more likely to deteriorate over time. Rehabilitation may involve assisting them with learning personal care of ostomies, finding or maintaining employment and encouraging them in areas of their lives where increased self esteem and assertiveness are needed.

Denial is the most common defense mechanism employed by the cancer patient. Weisman (1979) points out that a little denial never hurt anyone and can be useful both for clients and staff. The purpose of denial is to turn a problem into a non-problem which one does not need to cope. This strategy allows energy to be used for other purposes on a short term basis only. Since emotional inhibition tends to be one of the hallmarks of a Type-C personality, efforts are used through counseling to mobilize these emotions in a safe and non-threatening manner. Bresler, Acterberg, and the Simmontons use a Gestalt-like approach with the suggestion of an inner advisor and dialoging with pain, etc. LeShan has found aspects of rational emotive therapy to be helpful to motivate anger but does so with caution, sensitivity, and respect as he helps patients fight for their lives.

Whatever psychological intervention is employed to ease the discomforts experienced by cancer patients, the goal is always to improve the quality of life by helping them to acquire or expand their coping skills and to live more fully, even as they are dying.

Conclusions

The role of personality in the development and progression of cancer remains a debatable topic. There are correlates between health habits that lead to cardiac disease and those that lead to cancer, such as various excesses in diet, smoking and social habits. While an aggressive, social climbing personality is often the hallmark of the cardiac type A personality, the opposite, more passive and submissive Type C personality is attributed to those with cancer. Given this distinction, it seems logical that efforts need to be directed toward changing certain aspects of personality that lead to greater assertiveness and upgrading self esteem. Those who cope best in their disease process are those who assert themselves, who tend to ask questions, and insist upon sensible answers, not evasions, and who when dissatisfied, seek other opinions and treatments.

Of the three major methods of psychotherapeutic intervention, psychoanalysis seems to be the least practical. It is costly in terms of time, energy and finances and tends to be most stress producing. The relief

of the stress produced may never come before death. Very little information has been found in the literature regarding the Humanistic approach, yet most of the readings and the research have implied or promoted this less stressful-nonconfronting method of the Rogerian. Much of the literature does emphasize the need for reduction of stress since stress tends to wear away the immune system thereby making the individual more prone to the worsening of illness.

The Behavioral approach may incorporate the non-confronting ways of Rogers as well as educate the patient in assertiveness skills, how to adapt certain life style changes and specific methods to cope using the energies and abilities of the mind versus the body. In combining the two approaches, the unconscious mind can involve mental imagery, self hypnosis, dream recording-analysis, music and art; the conscious mind can tend to goal setting, positive affirmations, thought stopping, diary keeping for self-awareness, problem solving, and assertiveness training. In the realm of body/mind integration are various kinds of relaxation exercises and biofeedback.

As the number of cancer patients needing some form of therapeutic intervention outgrows the number of therapists prepared to work with them, the most cost effective means of reaching out is via a group experience. Through the educational model characteristic of the discipline of

counseling psychology, patients can be helped to learn how to think, solve problems, make decisions and share alternatives. Self help and support groups provide an ongoing comradery and encourage good coping skills.

The best psychotherapeutic approach for cancer patients would seem to be eclectic, with the incorporating of a variety of approaches dictated by the individual needs of each patient. This means that the mental health providers would need to evaluate and use a variety of methods and/or be willing to make referrals.

Much of the literature on the psychotherapeutic approaches for the client with cancer is limited in focus to a specific cancer, an isolated emotional entity such as depression or anxiety, or a particular approach. Of the research studies reviewed, many admit to a lack of validity of empirical results and many are criticized on methodologic grounds. Most of the studies reviewed on cancer personality are retrospective and speculative. Personality profiles do tend to change once a catastrophic disease is present. One study was an exception. A prospective investigation was conducted at the Western Electric Company in Chicago between 1957-1958 with both a 10 year and 20 year follow-up (19). It identified personality profiles prior to disease development. This study and others since then identify depression and repression as characteristics of the cancer prone personality. LeShan (1971) adds another dimension--

that of a major loss followed by an unrelenting feeling of hopelessness and helplessness. The anger that is a natural response to massive disappointment or loss is for some reason suppressed. It is possible that those who feel depressed, hopeless, and helpless do not bother to reach out for help to seek medical attention when the signs and symptoms of cancer first appear. Ergo, their cancer worsens.

It has become evident that there may be two entirely different kinds of cancer personalities or perhaps two different expressions with the same basic characteristics. There are those who are depressed, hopeless, and helpless and who have experienced major losses in their lives. Many of these individuals present themselves as passive and submissive to whatever comes their way. On the other hand, there are those persons who appear aggressive and motivated in their illness, and who go to great lengths to seek information and help no matter what the distance or cost. These are the people that Segal (19) refers to as "the exceptional cancer patients". The question remains as to whether they are exceptionally more motivated based on a higher socioeconomic and/or educational level; or are these, perhaps, the people who are genetically prone versus personality prone to cancer?

The psychotherapeutic interventions presented in this thesis have not indicated any specific preference in

approach offered to or sought by cancer patients of a certain personality. However, personal experience has shown that those cancer patients who attend expensive workshops and engage in the nonconventional methods described, tend to be of a higher education and socioeconomic level. From all appearances, it seems that those of a lower economic and educational level are not benefitted by the same learning resources available to their counterparts. More extensive examination of this observed difference is recommended.

The literature contains considerably more articles dealing with female versus male support groups. At least two questions remain regarding male patients: (1) Don't men have their own cancer support groups? and (2) How do men obtain educational and emotional support when needed?

Whatever psychotherapeutic intervention is utilized for cancer patients, it is always as an adjunct to the medical regime. Realistically, not all cancer patients need or seek therapy. The majority are unable to financially manage therapy on a 1-1 basis. Most cancer patients are treated in community hospitals not always affiliated with a university and therefore lack some of the opportunities of research projects. Networking, therefore, takes on greater importance.

Lastly, most of the work done in this area of oncotherapy is based on anecdotal reports and survey data with only a limited number of experimental studies having

been conducted in the past 15 years. More systematic study of this topic is necessary.

Recommendations

Conclusions based on this review lead to the following recommendations:

1. Since some persons seem more predisposed to having cancer in their lifetime, future research should attempt to identify and counsel people at risk due to general health habits. A psychosocial screening could be conducted in conjunction with employment physicals to identify those at risk for cancer. A cancer control project much like those for cardiac patients could be established in the workplace and offer diet and exercise in conjunction with weekly or monthly counseling sessions.

2. Because many persons with advanced cancer need to maintain employment as long into their illness as possible for the insurance benefit, some supportive measures are needed to assist these people in keeping a job given their need for daily radiation or chemotherapy treatments. A research study might examine how people manage employment with medical treatments and the effect of medical treatments on the employee, the employer and co-workers.

3. Since many cancer patients develop abnormally low platelet counts, a research study consisting of thrombocytopenic patients using mental imagery and/or dialoguing on a daily basis to increase number of platelet

is recommended. This would be feasible for hospitalized patients with central lines for blood draws.

4. In order to benefit a wider population, the establishment of an Oncotherapy Resource Center is needed and should be staffed with experienced personnel. Such an establishment could not only benefit patients with a variety of psychotherapeutic interventions but might also serve as an intern training center for the preparation of future mental health providers. There appears to be a greater need for qualified resource people in the inner city where the frequently neglected masses of multi-ethnic and low income populations reside. Community based Oncotherapy Resource Centers could therefore be established and be governed by both state and national headquarters.

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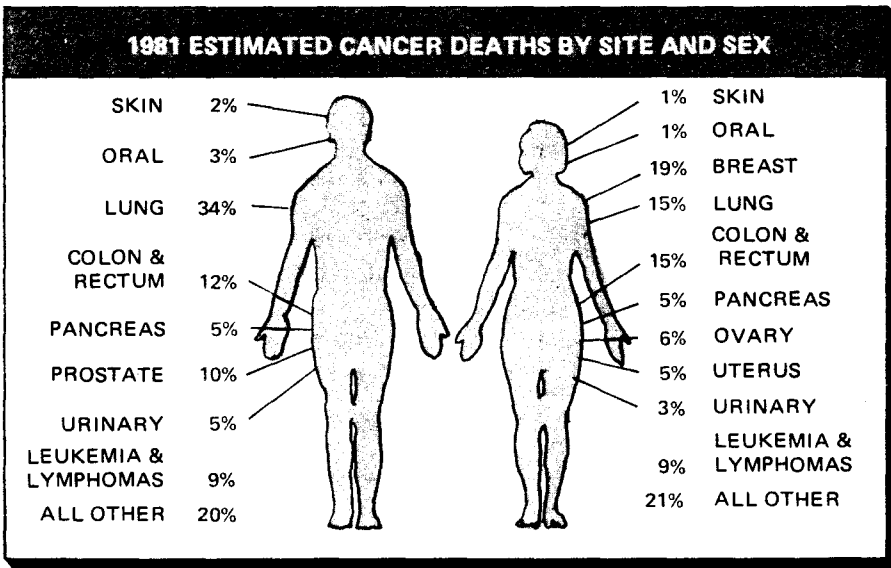
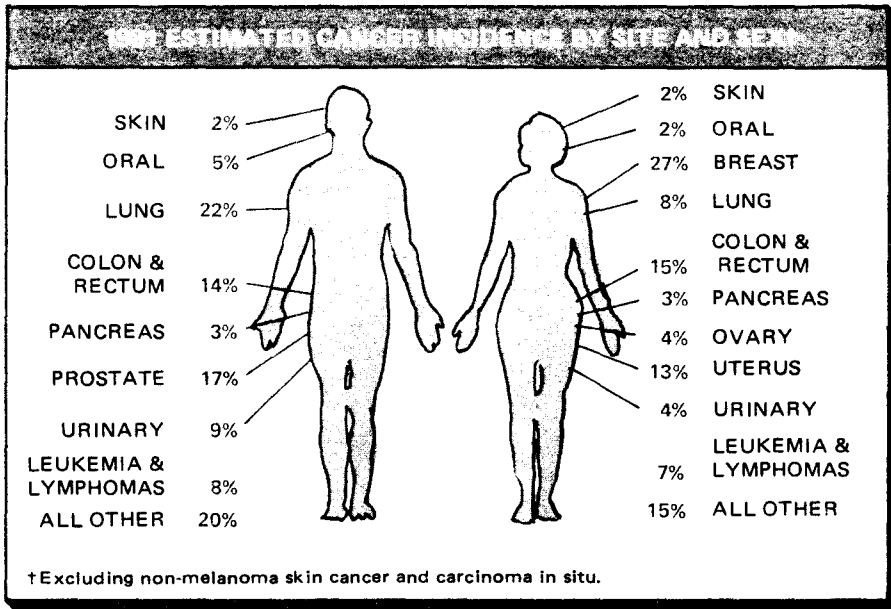
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APPENDIX A

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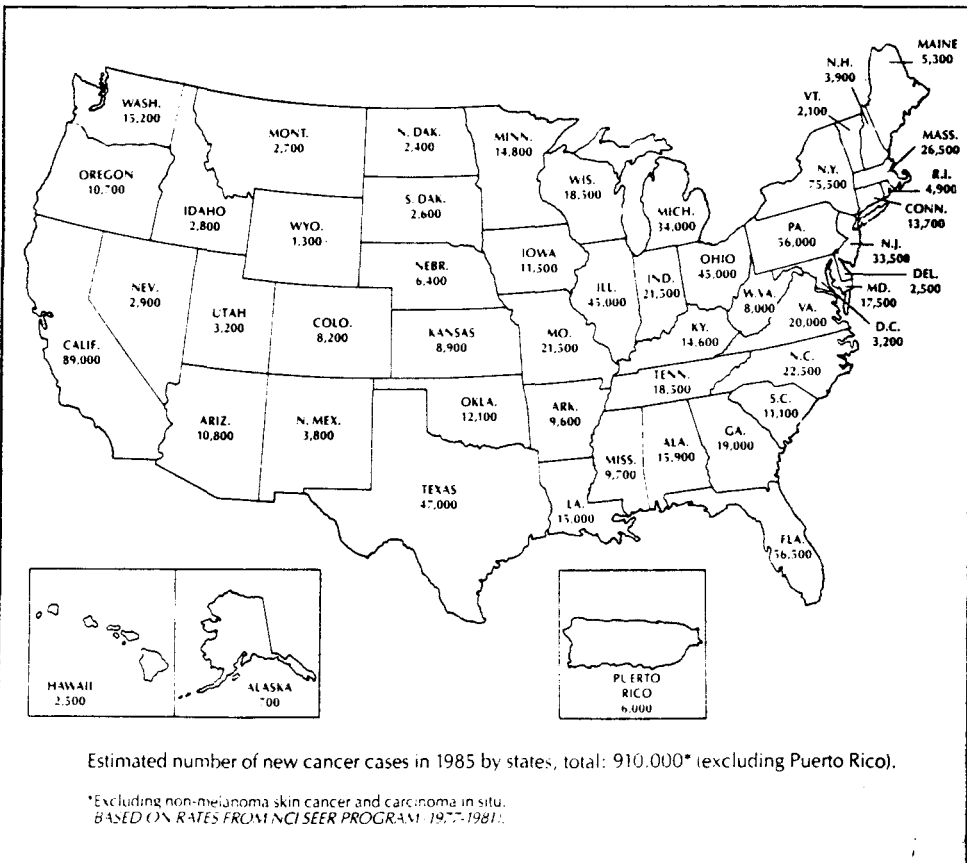
Cancer Statistics, 1981

The estimates of the incidence of cancer are based upon data from the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) Program (1973-1976). Non-melanoma skin cancer and carcinoma in situ have not been included in the statistics. The incidence of non-melanoma skin cancer is estimated to be over 400,000. Prepared by Edwin Silverberg, Project Statistician, Department of Epidemiology and Statistics, American Cancer Society, New York, New York.



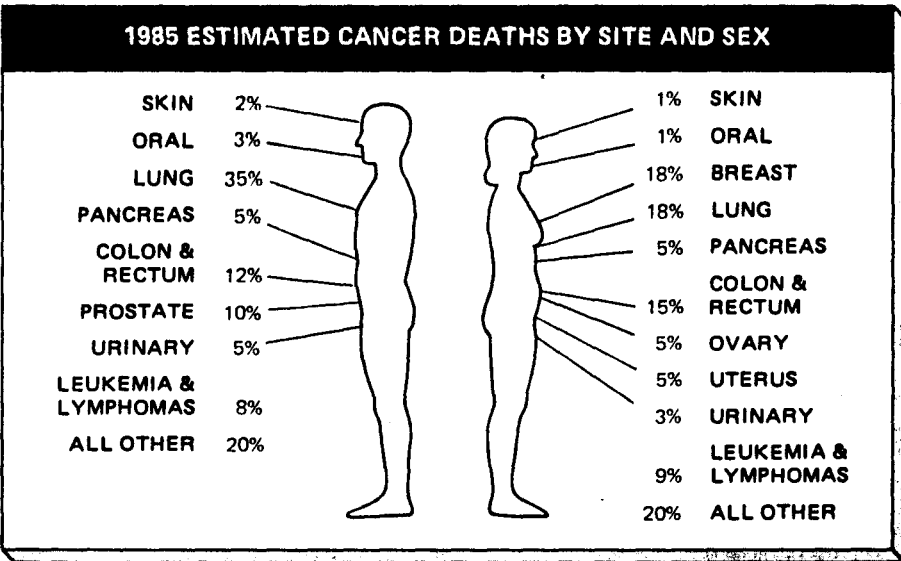
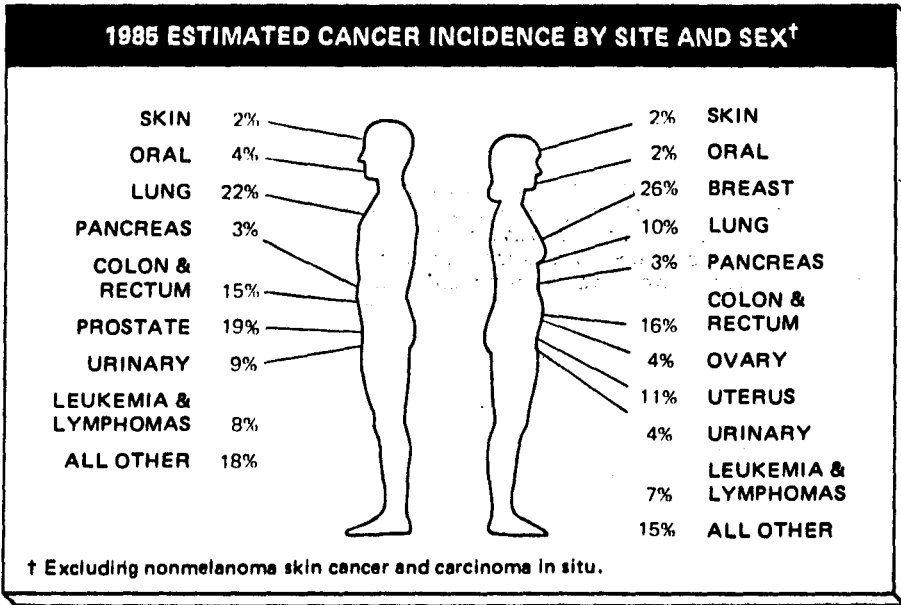
1985 CANCER FACTS & FIGURES

HIGHLIGHTS THIS YEAR:
 • New cancer survival rates
 • Nutrition and cancer • Cancer prevention



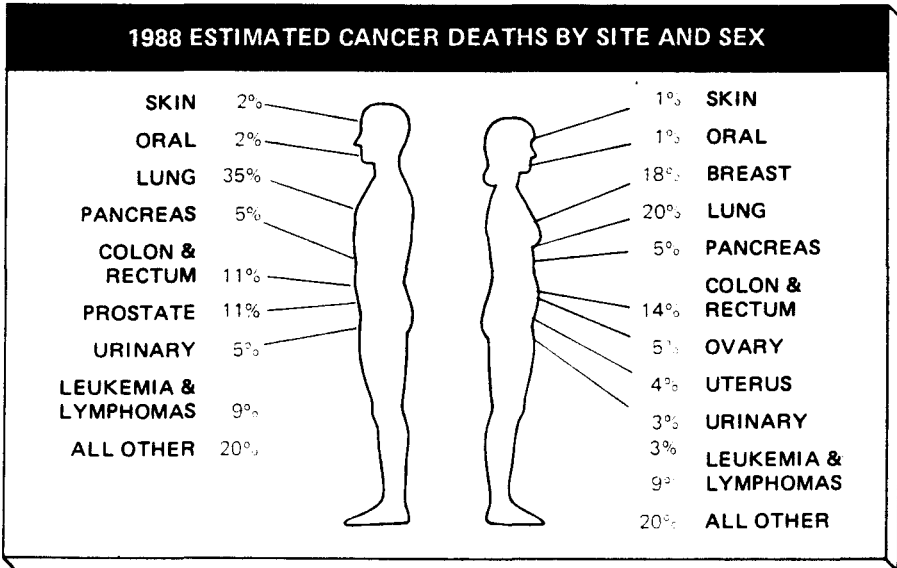
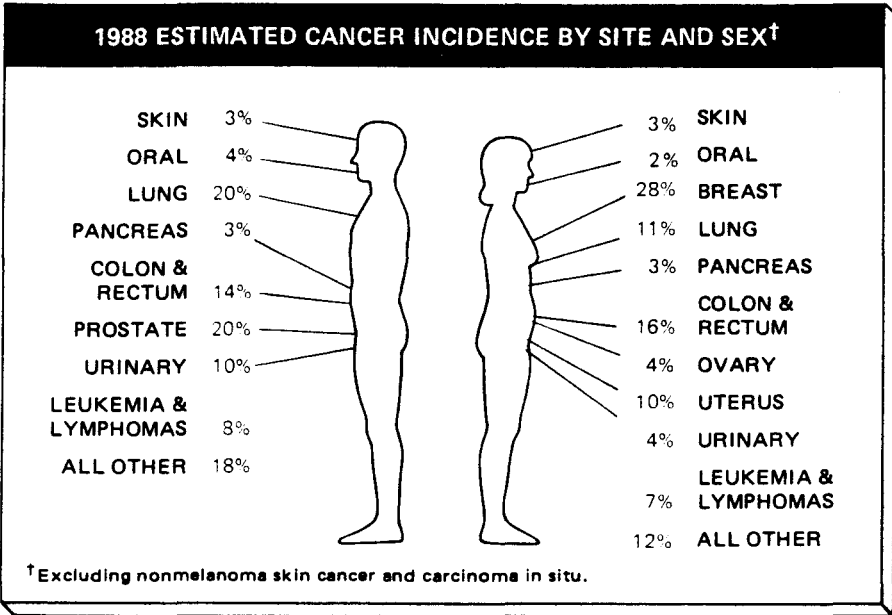
Cancer Statistics, 1985

The estimates of the incidence of cancer are based on data from the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) Program (1977-1981). Nonmelanoma skin cancer and carcinoma in situ have not been included in the statistics. The incidence of nonmelanoma skin cancer is estimated to be more than 400,000. Prepared by Edwin Silverberg, Supervisor, Statistical Information Services, Department of Epidemiology and Statistics, American Cancer Society, New York, New York.



Cancer Statistics, 1988

The estimates of the incidence of cancer are based on data from the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) program (1982-1984). Nonmelanoma skin cancer and carcinoma in situ have not been included in the statistics. The incidence of nonmelanoma skin cancer is estimated to be more than 500,000. Prepared by Edwin Silverberg, Supervisor, Statistical Information Services, and John A. Lubera, Statistical Information Technician, Department of Epidemiology and Statistics, American Cancer Society, New York, New York.





CANCER FACTS & FIGURES-1990



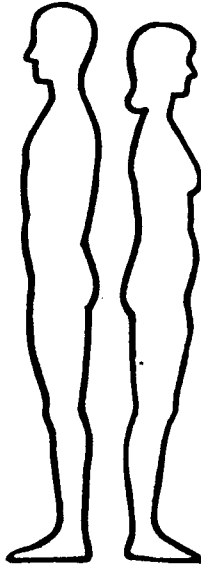
Estimated number of new cancer cases in 1990 by state, total: 1,040,000* (excluding Puerto Rico).

*Excluding nonmelanoma skin cancer and carcinoma in situ.
BASED ON RATES FROM NCI SEER PROGRAM (1984-1986).

SELECTED CANCER SITES

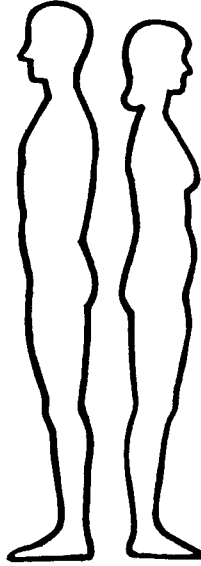
CANCER INCIDENCE AND DEATHS BY SITE AND SEX—1990 ESTIMATES

CANCER INCIDENCE BY SITE AND SEX*

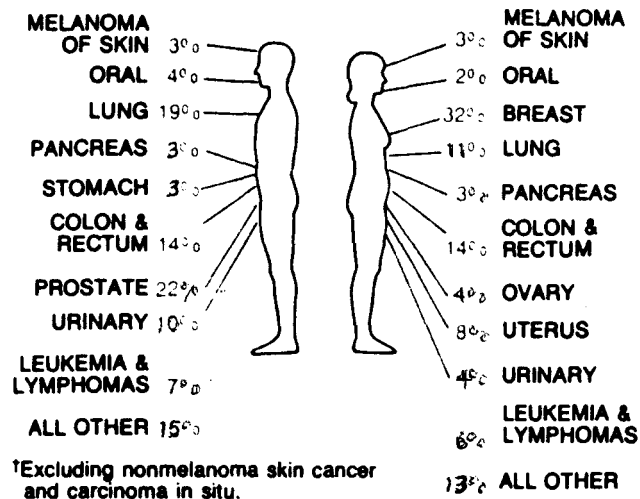
PROSTATE 106,000		BREAST 150,000
LUNG 102,000		COLON & RECTUM 79,000
COLON & RECTUM 76,000		LUNG 55,000
BLADDER 36,000		UTERUS 46,500
LYMPHOMAS 22,800		OVARY 20,500
ORAL 20,400		LYMPHOMAS 20,200
LEUKEMIAS 15,700		PANCREAS 14,500
KIDNEY 15,000		BLADDER 13,000
MELANOMA OF THE SKIN 14,800		MELANOMA OF THE SKIN 12,800
STOMACH 13,900		LEUKEMIAS 12,100
PANCREAS 13,600		ORAL 10,100
LARYNX 10,000		STOMACH 9,300

*Excluding nonmelanoma skin cancer and carcinoma in situ.

CANCER DEATHS BY SITE AND SEX

LUNG 92,000		LUNG 50,000
PROSTATE 30,000		BREAST 44,000
COLON & RECTUM 30,000		COLON & RECTUM 30,900
PANCREAS 12,100		PANCREAS 12,900
LYMPHOMAS 10,500		OVARY 12,400
LEUKEMIAS 9,800		UTERUS 10,000
STOMACH 8,300		LYMPHOMAS 9,300
ESOPHAGUS 7,000		LEUKEMIAS 8,300
BLADDER 6,500		LIVER 5,700
LIVER 6,200		STOMACH 5,400
KIDNEY 6,100		BRAIN 5,100
BRAIN 6,000		MULTIPLE MYELOMA 4,500

1991 ESTIMATED CANCER INCIDENCE BY SITE AND SEX



Cancer Deaths by Site and Sex, 1981

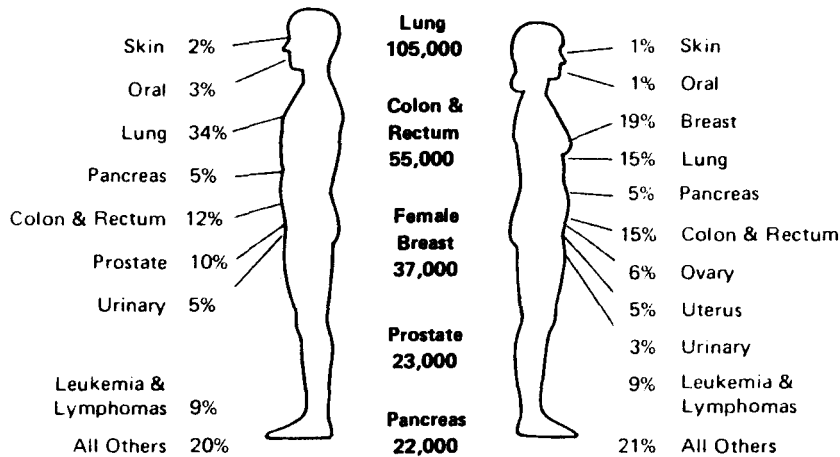
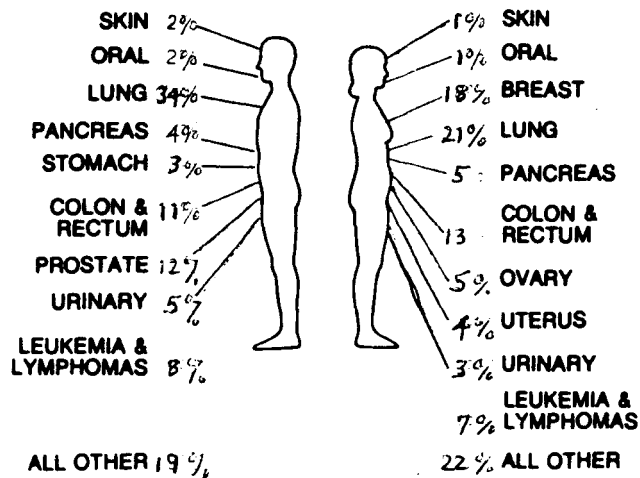
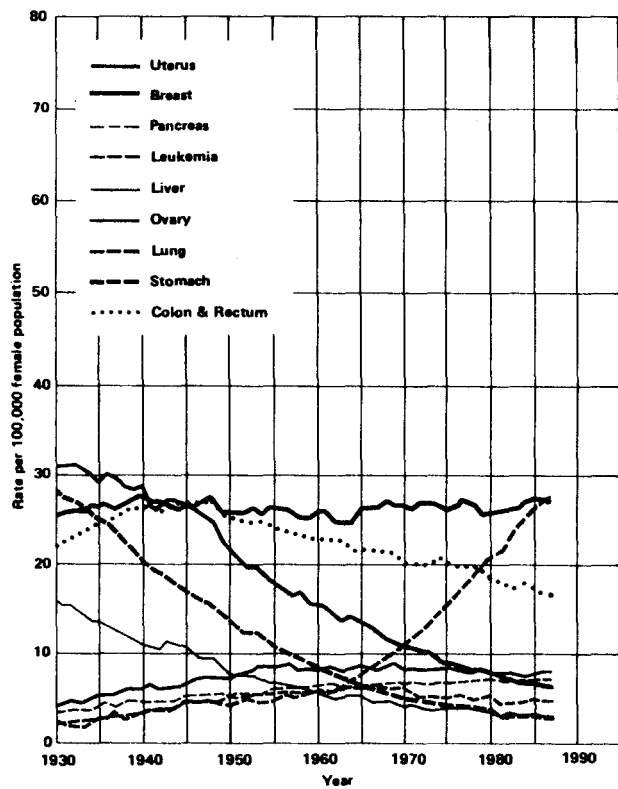


Fig. 1. Cancer deaths in males and females in the United States, showing pancreatic cancer as the fifth most frequent cause of cancer death in 1981.

1991 ESTIMATED CANCER DEATHS BY SITE AND SEX

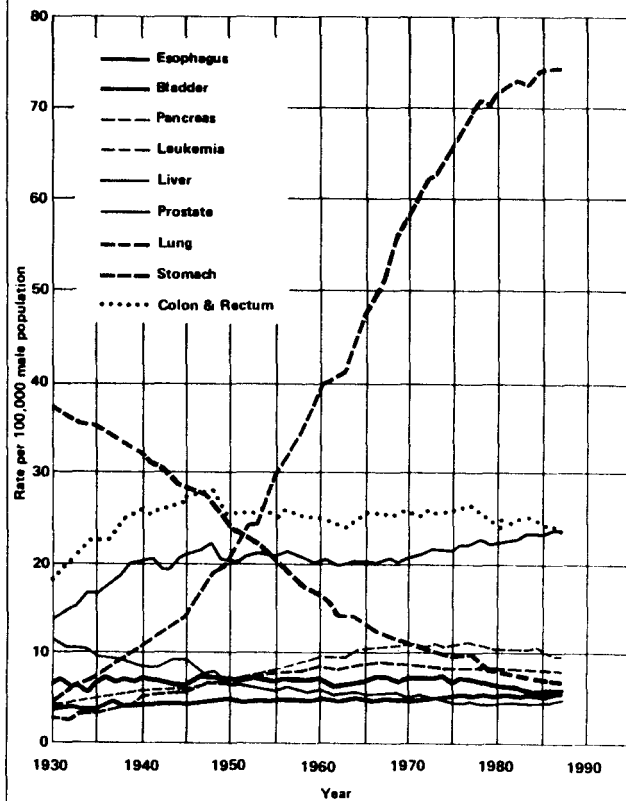


AGE-ADJUSTED CANCER DEATH RATES* FOR
SELECTED SITES, FEMALES, UNITED STATES, 1930-1987



* Adjusted to the age distribution of the 1970 US Census Population.
Sources of Data: US National Center for Health Statistics and
US Bureau of the Census.

AGE-ADJUSTED CANCER DEATH RATES* FOR
SELECTED SITES, MALES, UNITED STATES, 1930-1987



* Adjusted to the age distribution of the 1970 US Census Population.
Sources of Data: US National Center for Health Statistics and
US Bureau of the Census.

**TRENDS IN SURVIVAL
BY SITE OF CANCER, BY RACE**
Cases Diagnosed in 1960-63, 1970-73, 1974-76, 1979-84

Site	1960-63 ¹		1970-73 ¹		1974-76 ²		1979-84 ²	
	Relative 5-year Survival Rate (Percent)		Relative 5-year Survival Rate (Percent)		Relative 5-year Survival Rate (Percent)		Relative 5-year Survival Rate (Percent)	
	White	Black	White	Black	White	Black	White	Black
All Sites	39	27	43	31	50	38	50*	37
Oral Cavity & Pharynx	45	-	43	-	54	35	54	31
Esophagus	4	1	4	4	5	4	7	5
Stomach	11	8	13	13	14	15	16*	17
Colon	43	34	49	37	50	45	54*	49
Rectum	38	27	45	30	48	40	52*	34
Liver	2	-	3	-	4	1	3	5
Pancreas	1	1	2	2	3	2	3	5
Larynx	53	-	62	-	66	58	66	55
Lung & Bronchus	8	5	10	7	12	11	13*	11
Melanoma	60	-	68	-	78	62††	80*	61†
Breast (Female)	63	46	68	51	74	62	75*	62
Uterine Cervix	58	47	64	61	69	61	67	59
Uterine Corpus	73	31	81	44	89	61	83*	52*
Ovary	32	32	36	32	36	41	37*	36
Prostate	50	35	63	55	67	56	73*	60*
Testis	63	-	72	-	78	77†	91*	82†
Bladder	53	24	61	36	73	47	77*	57*
Kidney & Renal Pelvis	37	38	46	44	51	49	51	53
Brain & Nervous System	18	19	20	19	22	27	23	31
Thyroid	83	-	86	-	92	88	93	95
Hodgkin's Disease	40	-	67	-	71	67†	74*	69
Non-Hodgkin's Lymphomas	31	-	41	-	47	47	49*	49
Multiple Myeloma	12	-	19	-	24	28	24	29
Leukemia	14	-	22	-	34	30	32	27

¹Rates are based on End Results Group data from a series of hospital registries and one population-based registry.

²Rates are from the SEER program and include patients diagnosed through 1984 and follow-up on all patients through 1985. They are based on data from population-based registries in Connecticut, New Mexico, Utah, Iowa, Hawaii, Atlanta, Detroit, Seattle-Puget Sound, and San Francisco-Oakland.

*The difference in rates between 1974-76 and 1979-84 is statistically significant ($p < .05$).

†The standard error of the survival rate is between five and 10 percentage points.

††The standard error of the survival rate is greater than 10 percentage points.

- Valid survival rate could not be calculated.

APPENDIX B

INVENTORY OF CURRENT CONCERNS
(ICC)

Project Omega
Massachusetts General Hospital
Harvard Medical School
Boston, Massachusetts

Many of the statements listed below are true to some extent for everyone.

Please check the degree to which these statements have been *true for you* within the past month including today.

I am concerned about:

1. Feeling tired most of the time
2. Having lengthy treatments
3. Being more religious
4. Needing financial assistance
5. Having too many decisions made for me
6. How long I might live
7. Having to move away from my neighborhood
8. Being very lonely
9. Losing interest in things
10. My poor appetite
11. My persistent cough
12. Whether there is an afterlife
13. Future unemployment
14. Feeling rejected by my family
15. The future
16. Asking friends for help and assistance
17. Feeling anxious and restless
18. Being too careful to do the right thing

I wish that:

19. I wasn't losing weight
20. I wasn't bothered by headaches
21. I didn't doubt the value of prayer
22. I could work regularly
23. My family understood me
24. There were fewer quarrels at home
25. Friends were more dependable
26. I had more sexual satisfaction
27. I was not so honest and outspoken
28. I could get around better
29. I could get better treatment
30. I could get satisfactory help from religion
31. I could have a steady income
32. I could fulfill my spouse's expectations
33. I weren't so dependent on my family
34. I could see more of my friends
35. I weren't so discouraged
36. I didn't take things so seriously

	True	Somewhat True	Not True
1.			
2.			
3.			
4.			
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36.			

I am afraid that:

- 37. My stomach and bowels bother me
- 38. I occasionally feel faint
- 39. I don't get to church often enough
- 40. I will have to spend all of my savings
- 41. My marriage is breaking apart
- 42. I face an uncertain future
- 43. I am being a burden on my friends
- 44. I am too moody
- 45. I will be thought a bad person
- 46. My treatments are not satisfactory
- 47. I want more from my doctors
- 48. I'm losing my earlier religious faith
- 49. I'm not doing my job well
- 50. I'm not getting along with a member of my family
- 51. I am losing hope in the future
- 52. My friends treat me differently because of illness
- 53. I might hurt myself
- 54. I am getting too old

I would feel better if:

- 55. I didn't face an operation
- 56. I wasn't bothered by shortness of breath
- 57. I could feel closer to God
- 58. I could keep up with my work and chores
- 59. I could be closer with my family
- 60. I didn't have to live with relatives
- 61. I had a good friend to confide in
- 62. I could forget past mistakes
- 63. I was able to do more things for myself
- 64. I could sleep better
- 65. I had less pain
- 66. I weren't so indifferent to religion
- 67. I had enough money for medical expenses
- 68. My children were settled in life
- 69. My family could be counted on
- 70. I weren't alone so much
- 71. I weren't so irritable
- 72. I could think more clearly

	True	Somewhat True	Not True
37.			
38.			
39.			
40.			
41.			
42.			
43.			
44.			
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66.			
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68.			
69.			
70.			
71.			
72.			

Name _____ Date _____
Age _____ Sex _____ Primary _____ Months _____

	T × 2	+	ST × 1	=	Total	+	= % of category
HE					32		
RE					16		
WF					16		
FA					24		
EX					8		
FR					16		
SA					32		
Total:				$\Sigma =$	144		

APPENDIX C

SAMPLE

EXERCISE TWO: Your Goals

DATE: Feb. 7

TIME: 12 noon

	I want to	I've reached my goal when
1	return to work	I'm well enough to begin working at least 3 days a week
2	make love with Bill like we used to	I'm able to enjoy sex without pain
3	sleep more soundly	I sleep eight consecutive hours without awakening
4	stop taking pain pills	I can throw all my medications away
5	drive a car	I can drive by myself to Don's school
6	go to a movie	I can sit in a crowded theater comfortably for a straight hours
7	go to a nightclub and dance	I can stand the loud noises and dance without pain
8	not have to depend on doctors	I can stop seeing Dr. Carlton
9	travel to see my sister	I can visit Martha in Oregon at Christmas
10	climb stairs more quickly	I can climb 20 stairs, one right after the other

EXERCISE TWO: Your Goals

DATE: _____

TIME: _____

	I want to	I've reached my goal when
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Source: Bresler, D. (1979). Free yourself from pain. Permission granted from Simon & Schuster Publishers.

SAMPLE

EXERCISE THREE: Corresponding with Your Discomfort

DATE: Feb. 11
TIME: 6 p.m.

From: Peggy
To: PAIN

Dear Pain:

Why are you causing me so much misery? You've been interfering with my life for three years now, and I don't understand why. Sometimes I feel like I'm reaching the breaking point, like if you stay with me one more day, I'm just going to crack. I hope you'll be a lot more considerate of what I'm going through.

You've really messed things up. My husband and I don't get along very well anymore, mostly because I just can't do the things I used to do. I had to quit my job because of you and I resent you for that. When will you go away? Why won't you leave me alone? I can't afford to have you around anymore, either physically, psychologically or emotionally.

You've warped me into a different person. I feel sorry for myself. I'm depressed. My few remaining friends tell me I look terrible. I'm lonely. You're my most constant companion. And you're not making my life easy.

If you have something to tell me I'd like to hear it. If there's something I'm doing wrong for you to hurt me like this, let me know. You exhaust me and use up all my energy, but I'll find some energy to do whatever I have to do to get you out of my life. Please contact me soon, but gently.

Sincerely,

Peggy

EXERCISE THREE: Corresponding with Your Discomfort

DATE: _____

TIME: _____

From: _____

To: PAIN

Dear Pain:

Sincerely,

SAMPLE

EXERCISE THREE: Corresponding with
Your Discomfort

DATE: Feb. 11
TIME: 6:30 p.m.

From: PAIN
To: Peggy

Dear Peggy:

I'm sorry for what you're going through. Life is not always easy, and I realize that it is very unpleasant for you now. But there's a reason for it. I hope we can open up a dialog with one another, because I think I have a lot to tell you.

First of all, I hope you will trust me. Although I may be making your life difficult, there is a reason for it. And when this experience is all over (which I hope it will be soon), I hope you'll truly understand it.

In some ways, I think you've become a better person because of me. I think you've become a more sensitive person, and I know you've come to appreciate the people who stand by you when once you took them for granted.

But there are other reasons why I have become part of your life. It wasn't just a quirk of fate that brought us together. I have many more things to tell you as we get to know each other better. You have within you the ability to make your life what you want it to be, and I hope I can show you some of the ways to do that.

I'm so glad you contacted me. Please write again.

Sincerely,
PAIN

EXERCISE THREE: Corresponding with
Your Discomfort

DATE: _____
TIME: _____

From: PAIN
To: _____

Dear _____:

Sincerely,
PAIN

APPENDIX D

The Cancer Survivors' Bill of Rights

1. Survivors have the right to assurance of lifelong medical care, as needed. The physicians and other professionals involved in their care should continue their constant efforts to be:

- sensitive to the cancer survivors' lifestyle choices and their need for self-esteem and dignity;
- careful, no matter how long they have survived, to have symptoms taken seriously, and not have aches and pains dismissed, for fear of recurrence is a normal part of survivorship;
- informative and open, providing survivors with as much or as little candid medical information as they wish, and encouraging their informed participation in their own care;
- knowledgeable about counseling resources, and willing to refer survivors and their families as appropriate for emotional support and therapy which will improve the quality of individual lives.

2. In their personal lives, survivors, like other Americans, have the right to the pursuit of happiness. This means they have the right:

- to talk with their families and friends about their cancer experience if they wish, but to refuse to discuss it if that is their choice and not to be expected to be more upbeat or less blue than anyone else;
- to be free of the stigma of cancer as a "dread disease" in all social relations;
- to be free of blame for having gotten the disease and of guilt for having survived it.

3. In the workplace, survivors have the right to equal job opportunities. This means they have the right:

- to aspire to jobs worthy of their skills, and for which they are trained and experienced, and thus not to have to accept jobs they would not have considered before the cancer experience;
- to be hired, promoted and accepted on return to work, according to their individual abilities and qualifications, and not according to "cancer" or "disability" stereotypes;
- to privacy about their medical histories.

4. Since health insurance coverage is an overriding survivorship concern, every effort should be made to assure all survivors adequate health insurance, whether public or private. This means:

- for employers, that survivors have the right to be included in group health coverage, which is usually less expensive, provides better benefits, and covers the employee regardless of health history;
- for physicians, counselors, and other professionals concerned, that they keep themselves and their survivor-clients informed and up-to-date on available group or individual health policy options, noting, for example, what major expenses like hospital costs and medical tests outside the hospital are covered and what amount must be paid before coverage (deductibles).

Natalie Spingarn

APPENDIX E

A Friend Is

A person who thinks of us often, not because he has to or even wants to, but just because he does;

A person who feels for us and with us -- always when we let him and even when we don't;

A person who loves us deeply, but not possessively;

A person who realizes that true friendship involves neither the illusion of freedom nor the burden of oppressive demands;

A person who is sensitive and responsive to the subtle, almost inaudible pleas we make to him;

A person who occasionally fails us...and knows it...and tries to fix it...and learns from it;

A person who makes us feel vitally alive because he sees us as profoundly human;

A person who sees in us something he sees in no one else;

A person who loves us and in so many ways tells us so...and tells us so...and tells us so...and...;

A person whose death creates in us an ache, a despair, and an unfillable void.

Richard P. Issel PhD
(1938 - 1990)

APPROVAL SHEET

The thesis submitted by Rita Catherine Rogers has been read and approved by the following committee:

Dr. Gloria J. Lewis, Director
Associate Professor, Counseling and Educational Psychology,
Loyola

Dr. Carol G. Harding
Associate Professor and Chairperson, Counseling and
Educational Psychology, Loyola

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

4/12/91
Date


Director's Signature